Costs and funding of occupational diseases in Europe

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Foreword

The European Forum of Insurances against Accidents at Work and Occupational Diseases[1] set up, in September 1998, a group led by Eurogip in charge of working on the occupational diseases in Europe.

The work performed by this working group led to the publication of the following reports:

- *Occupational diseases in Europe – comparative study of 13 countries: reporting, recognition and compensation procedures and conditions* (Sept. 2000)
- *Occupational diseases in 15 European countries – Figures for 1990-2000, legal and practical news 1999-2002* (Dec. 2002)
- *Overview of occupational cancers in Europe* (Dec. 2002)
- *Survey on under-reporting of occupational diseases in Europe* (Dec. 2002)
- *Lumbago and allergic asthma: two case studies at the European level* (Dec. 2002)
- *Work-related mental disorders: what recognition in Europe*? (Feb. 2004)

The present study follows on from this work.

[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 risks and monitoring the process of convergence between the systems in place in the various countries of Europe. In 2004, seventeen countries - and twenty-three organisations - are represented in it.

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Introduction

It is sometimes hard to convince employers of the economic return on actions designed to make corporate working conditions healthier. And yet, occupational diseases have a cost: first of all a human and social cost for the victims and their relations, but also a financial cost for enterprises or even for society as a whole.

Clearly, occupational diseases represent a cost item for enterprises, which can legitimately be expected to increase further over the coming years in most countries.
Some costs are admittedly hard to quantify. Thus, the productivity losses due to absenteeism (interruption of the production process) and where applicable to the temporary or permanent replacement of the victim constitute an undoubted loss of earnings; the decline in attractiveness for any customers and for new personnel also has an economic impact that the company must allow for.
It is easier, on the other hand, to make a financial estimate of the cost of adapting work stations, of maintaining for a fixed length of time the wages of the insured employee absent due to disability (applied in some European countries), of the contributions paid by the company to the competent social insurance system for occupational diseases, or even of possible legal penalties inflicted on the company.
It is possible to make an economic assessment of what companies devote to occupational diseases in Europe by studying the expenses of the relevant national insurance organisations. Such is the purpose of the present report, which also deals with the question of funding for occupational diseases insurance.

However, the reader's attention should be drawn to the difficulty of this, since the social insurance systems have been built up based on the specific socio-economic history and concepts of each country. Depending on the type of economic activities and the content of the list of occupational diseases, there can accordingly be major differences in the number and nature of diseases for which compensation is paid. The scope and level of benefits provided for the insured, which differ greatly from one country to another, and the management procedures of each organisation, are all factors making the comparative approach difficult.

1. Cost of occupational diseases

A - The cost of compensation

a) Figures

Of the 11 European countries[2] taking part in the survey, two recognise that they are not able to give data on the specific cost of the occupational diseases, because the data available to them concern all occupational risks (accidents at work and occupational diseases) and they are not able to distinguish one from the other. These two countries are **Spain** and **Sweden**.
It should be specified that in **Sweden**, the only specific benefit for occupational injuries and diseases is a pension paid in case of permanent disability for loss of earning capacity, the cost of which amounted to about 454 million euro in 2000; benefits in kind and daily benefits (since 1st July 1993) are covered by health insurance irrespective of the cause of the disease: it is therefore impossible to distinguish, among all the benefits paid, between what is paid for an occupational disease and what is paid for a conventional disease.

France also has overall figures concerning accidents at work and occupational diseases, but it can, from risk rating information, make an estimate of the respective weights of each of these risks. The figure resulting from this estimate corresponds to the "value of the risk", in other words all the items representing expenses related to occupational diseases and chargeable to the accounts of the employers. It cannot be considered as a cost and thus compared to that of the other countries (See table 1), but it keeps its meaning in the framework of an analysis on a given period of time (See table 2).

The **Netherlands** are to be considered separately, because they have no specific occupational injuries insurance any more; in case of occupational disease, it is the sickness and/or disablement insurance systems that provide coverage for benefits in kind and cash benefits, and it is impossible to determine the specific cost of this type of disease as opposed to the cost of diseases in general.
The only order of magnitude available with regard to the cost of occupational injuries comes from a study performed by the insurance companies which pay compensation to victims who have brought civil liability suits against their employers. Such legal proceedings, frequent in the Netherlands, are estimated to cost the insurance companies between 100 and 250 million euro each year.

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Table 1 shows, for the year 2000, the cost of compensation for occupational diseases recognised both formerly and newly in seven European countries.

By compensation is meant:
- Benefits in kind such as healthcare and prostheses
- Benefits relating to rehabilitation
- Daily benefits paid in cases of temporary disability
- Pensions and capital payments in cases of permanent disability
- Pensions to legal beneficiaries and funeral expenses
- Benefits consisting of possible personal preventive measures (such as vaccination).

[2] Austria, Belgium, Denmark, France, Italy, Germany, the Netherlands, Portugal, Spain, Sweden and Switzerland

The amounts indicated exclude the administrative costs of the insurance organisation (wages, operating expenses, etc.) and expenses entailed in the collective prevention of occupational diseases, such as financial support for preventive measures taken by the enterprises or the production of informative materials designed for a sector of activity or a geographic region.

Table 1: Cost of compensation for occupational diseases in 2000

Country	Cost (in million of euros)	Insured population	Ratio per 100,000 insured persons (in million of euros)
Allemagne	1,223	34,000,000	**3.59**
Autriche	29.3	4,248,360	**0.69**
Belgique	334	2,656,456	**12.57**
Danemark	67	2,523,878	**2.65**
Italie	1,069	18,300,000	**5.84**
Portugal	36.7	5,113,100	**0.72**
Suisse	46.52	3,442,331	**2.11**

First of all, it should be specified that the « cost of occupational diseases per 100,000 insured persons » ratio is not relevant in itself, because it entails some limits (for example it doesn't take into account the weight of the past), but this indicator keeps its meaning in order to make a comparison between the countries.

The heterogeneousness of the costs mentioned above leads to the following comments:

One observes a difference of 1 to 18 between the country in which the amount of expenses devoted to the reparation of occupational diseases is lowest (**Austria**) and that in which it is highest (**Belgium**).
Although it is impossible to account for the position of each country in this ranking individually, basically two types of explanation can nevertheless be given for the differences observed.

A first series of reasons is due to the nature and quantity of occupational diseases recognised in each country.

- One cannot be unaware of the fact that the performance of certain industrial activities has consequences in terms of occupational diseases; thus, some countries such as **Belgium** and **Germany** even now bear a heavy burden of compensation for silicosis victims (see Table 5), even though their mining industries are declining or have ceased permanently.
- Likewise, the diversity of the content of the national lists of occupational diseases is a factor that should not be neglected. This is especially true for diseases such as lumbago and musculoskeletal disorders, which, depending on whether or not they are registered on the list, and based on recognition criteria specific to each country, can greatly influence the overall cost of compensation for occupational diseases. **Belgium**, for example, partly explains its high cost by the large number of recognised cases of lumbar osteoarthritis due to mechanical vibrations.

- Finally, the total cost of reparation also depends on the number of insured to whom compensation is paid (that is to say on the number of formerly and newly recognised cases for which benefits are granted), a variable which itself depends on numerous factors. If only the number of new cases of occupational diseases recognised in 2000 is considered, the difference is already from 1 (**Portugal**) to 4.5 (**Denmark**)[3].

The second type of explanation concerns the very great diversity of compensation systems prevailing in European countries. Although the figure shown in the table indeed represents the insurance organisation's total costs for the reparation of occupational diseases, the extent of this reparation varies depending on the country.

- In **Belgium**, **Denmark** and **Italy**, most of the cost of healthcare is excluded from the amount indicated, however, because medical care is mainly covered by the health insurance system or the National Health Service; the occupational diseases insurance system pays only the co-payment rate or a few specific treatments not otherwise covered. In **Austria**, the Allgemeine Unfallversicherungsanstalt (AUVA- Organisation in charge of occupational injuries insurance) plays a role in the reimbursement of medical care and medicines as of the fifth week of disability.
- The daily benefits paid in cases of temporary disability are not reimbursed by the occupational diseases insurance system in **Denmark**, while in **Austria** they are reimbursed only from week 27 on, and on condition that the insured is hospitalised.
- While the occupational diseases insurance system pays compensation for permanent disability in all the countries covered by the study, the cost of the benefits depends on numerous factors such as the type of damage indemnified, the minimum disability rate taken into account, the scales in force, the existence of a cost floor and ceiling, and the formula for pension calculation.
- Finally, some countries consider certain individual prevention measures as benefits, the cost of which therefore weighs on the "compensation" item. This may be in **Belgium** the purchase of gloves without latex in cases of allergic skin disease or reimbursement to some exposed workers of costs of vaccination against influenza and hepatites A and B, or again the cost of isolating pregnant women exposed to infectious diseases or ionising radiation, or whose fœtus could be exposed to certain noxious chemical products. In the same way, the amount shown for **Germany** includes the cost of preventive measures taken in the case of diseases which cannot be recognised formally as work-related (since the condition of abandonment of the dangerous activity by the insured is not met).

  Secondary factors can also explain the observed cost differences: **Italy,** for example, asserts that the rehabilitation benefits offered by its insurance organisation have a strong influence on the cost of reparation. **Switzerland** points out on its part that the effectiveness of its prevention systems no doubt make it possible to prevent the appearance of new cases of occupational diseases, but at the same time lead to the detection of existing cases for which compensation will have to be paid.

[3] Source : *Occupational diseases in 15 European countries - Data 1990-2000 New developments - 1999-2002, EUROGIP, dec. 2002*

b) Cost trends

Table 2: Cost of compensation for occupational diseases between 1996 and 2001 (in millions of euro)

Pays	1996	1997	1998	1999	2000	2001	2002
Germany	1,391	1,437	1,410	1,400	1,223	1,254.6	1,292
Austria	-	27.1	27.9	28.3	29.3	31.4	33.4
Belgium	361	348	348	326.5	334	335	336
Denmark	53	57	51	61	67	79	62
Italy	1,044	1,021	999	1,057	1,069	1,088	-
Portugal	26.2	28.1	27.5	36.3	36.7	41.8	49.6
Switzerland	40	49	52	70	46	50	-

The figures below given by France don't correspond to the overall cost of compensation but to the value of risk[4] as defined p.5.

Pays	1996	1997	1998	1999	2000	2001	2002
France	**-**	**-**	**493**	**633**	**790**	**853**	**-**

In many European countries, the expenses for compensation of occupational diseases trended toward relative stability between 1996 and 2002 (**Switzerland**, **Denmark**, **Austria**). Some countries (**Germany**, **Belgium**) even saw a decline in the cost over the period examined, even though the trend has been slightly upward since 2000.

- In **Switzerland**, despite a constant decline in the number of occupational diseases recognised throughout the decade 1990-2000, costs stagnated and even increased in 1999. This can be explained by the fact that light forms of occupational diseases have declined, whereas certain serious - and all the more costly - forms (such as mesotheliomas) have increased. Since 2000, the situation has become stabilised.
- In **Denmark**, there was a major increase between 1998 and 2001, due to the increase in the number of cases recognised and the appearance of more costly diseases. In 2002, however, the spending level of 1999 was able to be regained.
- In **Germany**, several trends resulting in a slight decline in the cost of occupational diseases over the period 1997-2002 are to be observed:
  The recognition of new diseases such as chronic bronchitis and coal miners' emphysema, and the general rise in the cost of healthcare and pensions, are factors in the increased cost of occupational diseases; but this effect is neutralised on the one hand by the death of insured who had been receiving pensions for many years for diseases such as silicosis

[4] The items charged to the employers' accounts take into account the amount of benefits in kind, daily benefits, capital compensation increased by 10%, of 32 times the amount of the initial pensions and 26 times the amount of the minimum pension payment for all deaths due to an occupational disease occurring whether or not the victim has legal beneficiaries. The amount of occupational reeducation costs is excluded. To the value of the risk have been added the expenses incurred to support the victims of occupational diseases registered on a special account for which the cost is mutualised, and occupational diseases following the inhalation of asbestos dust, recognised after reopening the files (Act of 23 December 1998), recorded medically between 1st January 1997 and 29 December 1998.

and deafness, and on the other hand by a fall, since 1996, in the number of claims for recognition and of cases recognised, and finally by the effectiveness of personal preventive measures for certain diseases (such as skin diseases), leading to a decline in reintegration and pension costs.

- In **Belgium**, after four years of falling costs for occupational diseases and a slight rise again in 2000, the trend is to stabilisation of spending. It is true that the number of new cases of occupational diseases is generally declining, but this is offset by the sharp increase in cases of temporary leave for pregnant women in harmful environments (the conditions for granting compensation were relaxed in December 2002).
  In **France**, **Italy** and **Portugal**, the cost of compensation for occupational diseases is increasing, although in different proportions depending on the country.

- In **France**, spending related to occupational diseases has been increasing continuously for about ten years now for the following reasons:
  The victims and family doctors are better informed about occupational diseases, namely asbestos-related diseases which lead to considerable expenses.
  Moreover, the chronic diseases of the lumbar rachis have been included in the tables of occupational diseases since 1999.
  Besides, one observes since 1997 a major increase (of approximately 60%) in expenses relating to daily benefits paid for occupational injuries, which can itself be explained by the increase in the number of people insured and accordingly in the number of claims, by the increase in average wages and by the increase in the number and duration of sick leaves (especially those exceeding 28 days).

- In **Italy**, the cost increase observed since 1998 concerns both pensions and compensation paid in the form of a capital sum; it can be explained by the increasing number of cases recognised and partly, also, by the increase in wages, on the basis of which pensions are calculated.
  It is too soon yet to measure the financial consequences of the introduction in July 2000 of the new Italian system of compensation for occupational injuries, which now offers compensation for new types of damage, especially aesthetic damage and damage to the reproductive system.

Sweden, although unable to give figures concerning the specific cost of occupational diseases in particular, indicates that the cost of pensions paid for lost earnings in cases of permanent disability due to work declined from 1996 to 2000; this can largely be explained by the 1993 reform of the system of recognition and compensation for work-related diseases, which reversed the onus of proof, which now rests on the victim, with as a consequence a fall in the number of cases recognised and hence a decline in the overall cost of benefits paid. Since 2001, on the other hand, the trend is to an increase, and a second reform in July 2002 lightening the onus of proof is expected to accentuate this increase, resulting in extra costs estimated at 100 million euro around 2006.

B - *Nature of expenses*

Table 3: Expenses for benefits, prevention and management costs as a proportion of the total cost of occupational diseases[5]

Pays	Benefits	Prevention cost	Management cost
Germany (2001)	71.2%	6.5%	10.1%
Austria (1999)	88%	5%	7%
Belgium (2003)	94%		6%
Denmark (2000)	90.5%	1%	8.5%
France (2002)	72%	4%	6%
Portugal (2002)	95%		5%
Switzerland (2000)	90%		10%

These percentages should be read cautiously, because some countries do not necessarily record all the expenses separately and on the basis of the aforementioned categories. Some types of costs (collective prevention, legal expenses, equipment and personnel expenses) may therefore appear under different headings according to the management methods applied in the insurance organisation in question.

Of course, benefits paid to the victims constitute by far the leading expense item. But there is a great difference between a country such as **Denmark** where benefits paid to the victims account for 90.5% of expenditures and others such as **France** and **Germany** in which these benefits slightly exceed 70% of the volume of annual expenditures.

Almost all the insurance organisations allocate part of their budget to prevention expenses. Although few countries specified what was the percentage of these expenses, it seems that there are rather great disparities between national situations. **Austria,** for example, specifies that the proportion of the budget devoted to prevention is tending to increase and could now amount to 7% of total expenses. In **Denmark**, on the other hand, the prevention of occupational diseases (and more generally of occupational injuries) is not the role of the organisation in charge of insurance, which explains the low proportion indicated in the table.

The proportion devoted to management costs can also vary, although without ever exceeding 10% of expenditures.

France points out that a significant proportion of the expenditures is assigned to transfers from occupational injury branch to the sickness insurance branch (330 millions euro for 2003) or, again, to other organisations, such as the Fonds de l'allocation de cessation anticipée d'activité des travailleurs de l'amiante (FACAATA - Fund for early retirement of asbestos workers) since 2000, and the Fonds d'indemnisation des victimes de l'amiante (FIVA - Fund

[5] In those countries in which accidents at work and occupational diseases insurance is managed by a sole organisation (which is the case in Germany, Austria, France and Switzerland), the percentages cover both accidents at work and occupational diseases.

for compensation of asbestos victims) since 2001. The proportion of such transfer expenditures has increased in recent years.

AUVA in **Austria** and Istituto nazionale per l'assicurazione contro gli infortuni sul lavoro (INAIL - Organisation in charge of occupational injuries Insurance) in **Italy** pay back each year a lump sum defined by law to the sickness insurance. This lump sum is paid to reimburse the cost of hospitalization, drugs and medical treatments granted by the sickness insurance to the victims of occupational injuries. This reimbursement respectively amounted to 127.6 million euro for AUVA in 2001 and to 200 million euro for INAIL in 2003.

Denmark also makes transfers to other organisations, for example to the Arbejdsmiljaradet (Council of Working Environment), but to a lesser extent.
Finally, **Germany** specifies that the 12% or so of expenses not allocated in the table are designed to establish reserves.

C - Part of occupational diseases in the whole occupational injuries

Belgium and **Portugal**, countries in which occupational diseases are managed by an organisation separate from those managing the "accidents at work" risk, are not able to complete the following table.

Table 4: Weight of the occupational diseases in the whole cost of occupational injuries in 2000

Pays	Ratio cost of ODs / whole cost of occupational injuries	Ratio number of recognised ODs / whole number of recognised occupational injuries
Germany	16.5%	1.24%
Austria	10%	0.8%
Denmark	25.9%	13.6%
France	Between 5% and 6%	2.55%
Italy	21%	1%
Switzerland	8%	1.38%

The first observation that can be made is that in every country, the "cost" ratio is far higher than the "number" ratio: an occupational disease costs on average far more than an accident at work, no doubt due to certain diseases recognised in large numbers and of a severity such that they justify the payment of a maximal pension (mesothelioma).

The data for **Germany**, **Austria** and **Switzerland** are relatively homogeneous. **Denmark,** on the other hand, is distinguished by an over-representation of occupational diseases among all the occupational injuries recognised, with a ratio of 13.6% compared with an average ratio of 1.4% in the other countries. Moreover, the data in the table suggest that the average cost of an occupational disease is particularly high in **Italy**.
As was already outlined in pages 6 and 7, these differences - or at least part of them - can be explained on the one hand by the diversity of the compensation systems and on the other hand by the type and number of occupational diseases recognised in each country.
To this should be added a few explanations specific to certain countries:

In **Austria**, an occupational disease (just like an accident at work) is recognised and recorded statistically only if it gives rise to the payment of a pension (which in Austria implies a permanent disability rate of at least 20%).
In **France**, there exists a special system for the compensation of miners which implies, in practice, that the general Social Security regime does not have to pay very costly compensation for the silicoses by which this population may be affected.

D - Occupational diseases generally most costly in Europe

Table 5: Breakdown of the cost of occupational diseases by disease group (% of total cost of compensation) on the period 1999/2001

Type of disease (cancers included)	Diseases caused by exposure to asbestos dust	Skin diseases	Diseases of the respiratory tract (except asbestos and silica)	Locomotor apparatus (MSDs and lumbago included)	Deafness due to noise	Diseases caused by exposure to silica	**Total**
Germany	20.5%	10.9%	8.8%	8.1%	13.9%	22.9%	**85.1%**
Belgium (2002)	4.69%	4.32%	9%	25.59%	4.75%	37.5%	**85.85%**
Denmark (2000/2002)	17.6%	15.35%	1.70%	37.60%	2.52%	0.85%	**75.62%**
France	48%	0.3%	2%	35%	0.5%	1.5%	**87.3%**
Italy	17.66%	12.71%	5.85%	11.56%	29.89%	6.39%	**84.06%**
Switzerland	30.2%	17.9%	10.8%	5.2%	10.2%	3.5%	**77.8%**
Average	**23.1%**	**10.2%**	**6.3%**	**20.5%**	**10.3%**	**12.1%**	**82.5%**

Sweden mentions musculoskeletal diseases as the most costly group of occupational diseases.

The **Netherlands** can provide us with information only concerning the cost of mesothelioma. In fact, the Institute for Asbestos Victims proposes a lump sum of about 40,000 euro to victims whose case is proved, and 10,000 euro to those for whom the company in which the disease was contracted no longer exists. The number of people who accepted this transaction in 2002 being 95 in the first case and 93 in the second case, the cost of mesothelioma for that year can be estimated at 4.73 million euro, excluding all legal proceedings.

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It is interesting to note that the five types of diseases generally most costly for the occupational disease insurance organisations by themselves account for between 75% and 87% of the total cost of occupational diseases sustained by each of them.
In Table 5, it is logical to find in almost all cases the diseases most commonly recognised in each country (See *Occupational Diseases in 15 European countries - Figures for 1990-2000 - Legal and practical news 1999-2002, EUROGIP, Dec. 2002).*

The classification of the disease may, however, be different in terms of recognition and in terms of cost.
Whereas in 2000 hearing loss ranked first among the diseases most commonly recognised in **Germany** and second in **Denmark**, its ranking in terms of cost is third and fourth respectively. Conversely, although the diseases caused by exposure to asbestos dust are almost always the most costly diseases, they generally rank only fourth of the diseases most commonly recognised. These discrepancies can be explained logically by the difference between the cost represented by each of these diseases individually.

At the European level, the percentages of costs for the most costly diseases are relatively uniform for diseases caused by asbestos, skin diseases and diseases of the respiratory tract. On the other hand, the proportion of costs for musculoskeletal disorders, deafness and diseases caused by silica vary greatly depending on the country.

Here again, the reasons explaining the differences observed from one country to another are, first of all, the specific nature of the industrial activities performed, mining activities in **Belgium** and **Germany** being the reason for the high percentages for diseases due to exposure to silica. On the contrary, **Denmark's** decision to reduce as of the 1970s its heavy industry activities to develop technology and service activities explains the very low percentage of silicoses in this country. It should also be specified that, in **France**, miners are insured by a special regime, and the cost of the silicoses from which they suffer therefore does not appear in the table.

The differences are also due to the diversity of the conditions for recognition of occupational diseases and the compensation procedures applicable in European countries. This is especially true for musculoskeletal disorders and lumbagos: for example, the fairly broad criteria for recognition (up to 2002) of osteoarticular diseases caused by mechanical vibrations explain the high proportion of costs assigned to this group of diseases in **Belgium**. Moreover, the practice of "useful rates" in force both in Belgium and in **France** (i.e. the granting of a pension whose rate is reduced for minor permanent disabilities and, in France, increased for major disabilities) may explain the low financial cost of hearing loss and skin diseases in these countries. In addition, **France** explains that hearing loss is even less expensive because it does not require any medical treatment nor any payment of daily allowances but only the payment of a pension which is often granted late when the insured goes into retirement.

Besides, **Italy** explains the extremely high cost of deafness due to noise by the inexistence, up until 1997, of clearly defined criteria for recognition of this disease at the national level; even now, this country has to bear the financial consequences of a very "generous" and disparate recognition by the regional units of INAIL.

2. *Funding of occupational disease insurance*

A - System of funding

a) Revenues of the same type

In all countries taking part in the study, revenues come from contributions payable exclusively by the companies and self-employed workers (when they are insured).
France specifies, however, that in practice 15% of receipts are payable by the state, due to miscellaneous exemptions from employers' social security contributions.

Some countries (**Austria**, **France** and **Switzerland**) have also indicated other sources of revenues, but which can be marginal: interest income and recourse against third parties, the latter applying rather to accidents at work than occupational diseases. In **France**, these two sources of revenues represent respectively 1% and 3% of the receipts. But they are not negligible in **Switzerland** since in 2000, interest income represented more than one fourth of Schweizerische Unfallversicherungsanstalt (SUVA- Organisation in charge of occupational injuries insurance) receipts and each year recourse against third parties yields about 140 million euro.

b) Different pricing rules

It should first be noted that, in those countries in which accidents at work and occupational diseases are managed by the same organisation, a single rate of contribution is applicable to the enterprise: no distinction is made between the part due for accidents and the part due for occupational diseases.

There are two different categories of country:

- The countries, where the enterprise's contribution rate varies depending on the business carried out by it (scales are planned for each branch of activity) and/or the extent of insurance claims observed in the enterprise.

  In **Switzerland**, **Italy**, **Germany**, **Spain** and **Denmark**, the rate differs according to the branch of activity.

  In **Denmark,** the contribution rate is calculated on the basis of the cost of occupational diseases over the last three years and the level of employment in each branch.

  In **Germany** and **Switzerland**, there exists, in addition to the risk classes according to the activity, a merit rating (bonus-malus) system which allows for the specific situation of the enterprise with regard to accidents at work.

  In **France**, for small enterprises, the contribution rate is set according to the activity carried out, while for large enterprises it depends largely on the accident rate observed in the plant.

- The countries, where in the name of inter-company solidarity, a single rate of contribution is applied to all enterprises whatever their activity, the number of their employees or the risks generated by them: 0.68% of the payroll in **Sweden** and 1.40% in **Austria**; 0.5% in **Portugal** and 1.1% in **Belgium**, knowing that, in both these countries, the occupational diseases insurance system is separate from the accident at work insurance system.

B - Financial balance of the Accidents at Work and Occupational Diseases branch

It seems clear, that the financial balance of the Accidents at Work and Occupational Diseases branch or, when the two risks are managed separately, of the organisation responsible for insurance against occupational diseases, is not a problem, at least in the near future.

Several countries even indicated that the accounts in the branch posted surpluses: This is the case in **Spain** where the Mutuas[6] have on the whole generated surpluses for about the last ten years, of which they allocate 80% to accident prevention and rehabilitation, 10% to the improvement of welfare aid, and the remaining 10% to the formation of provisions.

Sweden also generates surpluses, but only for the last few years. The July 2002 reform should however result in a new cost increase, but it is too soon yet to measure the impact of this.

Finally, **Austria** generates surpluses, despite the coverage, since October 2002, of half of the wages which continue to be paid to the victim of a temporary disability working in an enterprise of less than 50 employees during the first six weeks (in the form of a reimbursement to the employer).

In **France**, this was also the case up to 2003, in which year there was a deficit due to a fall in revenues, to payments made into the Fund for compensation of asbestos victims, and to an increase in the quantity of daily benefits.

C - Financial balance of the Accidents at Work and Occupational Diseases branch

Belgium, **Luxembourg** and **Denmark** assert that the system of funding for the "occupational diseases" risk receives no criticism in their country.

Spain specifies that there are no specific criticisms for the "occupational diseases" risk – the criticisms are apparently more general and concern the entire "occupational injuries" branch.

In December 2002, the Spanish Ministry of Labour and Social Affairs and the social partners agreed to a number of measures designed to improve the prevention of occupational injuries in enterprises, including the introduction in the risk-rating of a bonus/malus system, a proposal which is currently being examined.

In **Austria**, the criticisms come from the employers, who demand a reduction in the contribution rate. Likewise, the question of privatisation of the Social Security system is once again topical.

In **Sweden**, there is no real criticism of the current system. But some people assert that an equal contribution rate for all hardly encourages the employer to improve the work environment. Others point out that the introduction of a differentiated contribution system could encourage the creation of a selective labour market to the extent that, for financial reasons, employers would tend not to employ people who are in poor health and likely to be expensive in terms of insurance costs. Moreover, such a system would lead to an increase in management costs. Finally, the introduction of a differentiated contribution system would compromise the very principle of the general social insurance system: systematic redistribution among risk groups.

[6] Spanish mutual companies in charge of occupational injuries insurance

In **France** too, it cannot be said that there is a real debate on the question of financing of occupational diseases. However, the associations defending victims generally adopt a position in favour of greater individualisation of risk-rating, whereas the employers' associations defend, in some cases (e.g. for asbestos-related illnesses), a greater mutualisation of the risk.

In **Switzerland**, the criticisms do not concern the financing system for occupational diseases, but the concept of occupational diseases which is apparently too restrictive and does not make sufficient allowance for current constraints in the working world (stress, mobbing, etc.). If the range of diseases were to be extended, then the question of the system's financing would possibly be posed.

In **Germany**, it is likewise the concept of occupational disease that bears the brunt of criticism by the social partners, with the employees' representatives criticising the excessively restrictive conditions of recognition and with the employers' representatives refusing to fund the compensation of multifactorial diseases.

EUROGIP is a Public interest grouping (groupement d'intérêt public) formed by the National Health Insurance Fund for Employees (CNAMTS) and the National Research and Safety Institute (INRS) in order to organize, coordinate and develop at the European level the actions of the French Social security system regarding occupational hazards.

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