Promoting reporting and prevention of occupational diseases and the role of the new ILO list and the new ICD11

Claudio Colosio
“Any disease contracted as a result of an exposure to risk factors arising from work activity” (Protocol of 2002 to the Occupational Safety and Health Convention, 1981 (No. 155))
Whilst the diagnosis of a disease is CLINICAL
The classification of a disease as “Occupational” is based on an ADMINISTRATIVE DECISION
In most countries of the world, a disease can be defined “occupational” when the national authorities responsible for occupational diseases diagnosis and reporting acknowledge its occupational origin.

The main tool available to national authorities to acknowledge the occupational origin of a disease are the LISTS.
Comparison of three key-elements between EU Member States:

- Recognition
- Prevention
- Compensation
The “hybrid” structure of most lists

Diseases scheduled partially per agent and partially per apparatus affected

• Example:

• Diseases caused by chemical, physical and biological agents

• Diseases per target organs: respiratory, skin, musculoskeletal and mental diseases
The European situation

26 out of 29 Countries have national Lists of Occupational Diseases
Mostly “closed”, with the possibility of considering a disease “occupational” even if not included in the list after proof of its occupational origin.

In agreement with ILO approach: the so called “open Items”
The ILO “Open Items”: example

Diseases caused by other ..... agents at work not mentioned in the preceding items where a direct link is established scientifically, or determined by methods appropriate to national conditions and practice, between the exposure to these chemical agents arising from work activities and the disease(s) contracted by the worker
ILO and EU lists: differences and similarities

- Both only RECOMMENDATIONS
- Differences in classification criteria: musculoskeletal disorders in the ILO List physical agents EU
- In both «mixed» classification: causal factors/organs
- EU: a sub list of «limited evidence» not present in the ILO list
- A specific list of occupational neoplasms (ILO) not present in the EU list
- Free silica and formaldehyde indicated as carcinogenic agents in the EU list and not in the ILO list
• Low countries, Czech Republic: adopted the EU list
• Croatia: mostly similar to EU list
• Bulgaria, Latvia, Lithuania, Portugal, Slovak Republic (47 diseases) and Spain: scheme similar to EU, based on two levels of evidence (found only in original language)
• Romania: harmonization versus EU in course (73 diseases)
• The same Germany, but in some cases (benzo (a) pyrene, asbestos) criteria are reported regarding the probability of occupational origin
THE LISTS IN EU

• France: 98 tables per causal agent/related disease. Heading «bis» for tumours caused by the same substance.
• Ireland: a list per CAUSAL AGENT. Particularly large the part on occupational lung disorders (56 diseases).
• Estonia: list per risk factor. An example of heading not present in any other list of physical risk factor: nodule of vocal cords consequent to use (in the second list of Italy)
• Slovenia: list of diseases caused by chemical, biological and physical agents, followed by a series of diseases per organ/system with a specific session on orto and paradental diseases.
THE LISTS IN EU

- Greece: since 1979
- Hungary: list of 35 diseases
- Sweden: they have not any list of occupational diseases
Main Comments

Differences in:
Structure of the lists (open vs closed; per agent vs per disease)
Number of diseases considered (37 - more than 90)
Aims of the lists: reporting; compensation; prevention
Non univocal definition from Recommendation 2003/670/EC (prevention/compensation)
The degree of exhaustiveness of the lists varies. Short list of substances supplemented by a few precisely specified diseases (e.g. Switzerland), or else a list of diseases together with compulsory or indicative criteria for recognition (France, Italy, Spain and Portugal) This applies on a worldwide basis.
ODs reporting in Europe: some data

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All countries Total: 143,491, 143,308, 145,039, 431,838

> 10,000 cases for 2013 - 15
A further example and some thoughts

An urgent need: harmonization!!!

How to reach?

Bureaucratic vs Substantial

No harmonization without CRITERIA!
In Italy there are two list of ODs

1. List of diseases that must mandatorily be insured by the employer, divided in two sub lists (industry and agriculture).

2. Lists of diseases to be mandatorily reported to Italian Authorities (Enterprises for Health Protection), part of the Italian Public Health System, with power of inspection/report/punishment.
A disease can be defined “occupational” when the Italian law acknowledges its occupational origin and insert it in a list.

In some cases, the occupational origin can be acknowledged after a civil court trial.
When Italy acknowledges a disease as “occupational”?

“Automatic” acknowledgement if

• the disease
• the agent

Are in the Italian list of diseases that must mandatorily be insured by the employer (last updated: 2008)

In 2008 new diseases have been added to the list
Trends of reporting vs changes in the list in Italy (agriculture, 2004-2017)
Nuove sfide per la medicina del Lavoro: Immigrazione, Promozione della salute

Trends of reporting vs changes in the list in Italy (agriculture, 2004-2017)

Changes in the list

WHY?
“Trends in OD within Europe and is consistent with a positive impact of European initiatives addressing exposures relevant to asthma and contact dermatitis. Taking a more flexible approach allowed comparisons of surveillance data between and within countries without harmonisation of data collection methods”.
Above the list: prospects

- Different approaches and procedures for diagnosis
- Different meanings of words in different languages
- Difficulty in comparing data from different countries
- Main need: an harmonized approach (agreed diagnostic and exposure criteria)
Appointed in 2011

Task: preparing documents on diagnostic and exposure criteria

1 mini-monograph for each of the diseases/entities in the ILO list

“Open Items”: examples

Work finalized this year
The ILO working group’s approach

• Prepared 100 six-section short monographs
• Taken into account national practices
• Taken in consideration different systems in different regions
• Used expert opinions to summarize evidence.
• Retrieved scientific, technical and regulatory information
The Structure of the mini monographs

Six sections:
1. General characteristics of the causal agent/disease;
2. Occupational exposures;
3. Short profile of the toxic agent / disease;
4. Name(s) of the disease(s) and the related ICD-10 codes
   – acute, chronic and long term criteria for diagnosis,
   – minimum levels of exposure,
   – latency and induction period
5. Criteria for prevention
6. Further reading
The added value of ILO list & Criteria

• This product was a cooperative effort of volunteering scientists
• All main geographic and economic areas of the world represented
• This product in printed and digital forms will empower health and safety professionals and stakeholders in particular the developing countries
• Unique tool to promote harmonization of the approach to recognition, diagnosis, prevention and compensation of occupational diseases
The UN world united for the benefit of human kind

Merge of the ILO list of Occupational Diseases with the new edition of the WHO ICD-11

- Occupational diseases
- Diagnostic criteria
- WHO Identification codes
Workers’ health surveillance: implementation of the Directive 89/391/EEC in Europe

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“Coverage and quality of occupational health surveillance should be evaluated to facilitate learning from good practice and from scientific studies. We propose a serious debate in the EU with the aim of protecting workers more effectively, including the use of evidence-based WHS programmes”.
The role of coverage

Lists are useless if there is not health surveillance!
Workers’ access to health care programmes is the second key element to promote diagnosis, reporting and prevention of occupational diseases.
OHS Coverage in the World: some estimates

- Total Workers
- Agricultural Workers
- Not Covered Agricultural
THE SCENARIO

• In typical developing regions the OHS coverage ranges from 5 % to 10 % at best
• Agriculture, the self-employed, small-scale enterprises and the informal sector are usually not covered at all
• In European regions wide variation among countries: 5-90 %; Central and Eastern Europe: in transition
• USA, Canada, Japan, Australia, Israel: coverage comparable to Western Europe
• Agricultural and self-employed underserved
• The problem of family subsistence agriculture, daily paid labourers in plantations, seasonal or migrant workers and child labourers

Only a small proportion of workers provided with health surveillance at the workplace. Lowest levels in developing countries, agriculture, building trading and informal sector.

Among those who are exposed at the same levels of risk only a small proportion is provided with occupational health care.

Same levels of risk exposure addressed in different ways.

UNDERREPORTING OF OCCUPATIONAL DISEASES AND ACCIDENTS

DENIED A BASIC HUMAN RIGHT, THE RIGHT TO HEALTH
The lists’ users: who reports

Occupational Health physician vs other physicians
Report to employer/authorities
Role of the employer
Role of the employees
ODs together with general diseases - The Netherlands experience
Some thoughts

Reporting, diagnosis and compensation of Ods is made by two main ingredients

1. The workers’ access to OHS programmes
2. The availability of sound reference information
Report/recognition/compensation: which is the “right” information to be used?
ILO list & related criteria (soon available)
ICD 11
Conclusions

• Underreporting as universal problem in occupational diseases surveillance.
• Differences in the grade of reporting/underreporting between countries can be explained by differences in recognition systems:
  - active versus passive surveillance,
  - incentives for victims and medical doctors,
  - different inclusion criteria,
  - differences between recognised and compensated cases).

• Awareness of these differences is important
• Trend analysis over years to drive interventions
• CRITERIA
• Workers’ health surveillance