

## LEGISLATION ON OCCUPATIONAL DERMATOSES

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**Abstract.** The existence and application of legislation in the field of occupational diseases with regard to compensation for and prevention of occupational dermatoses and the rehabilitation of sufferers therefrom has been compared in thirteen European countries and California. It is evident that even in countries with well developed public health services a special law covering occupational diseases has advantages. It encourages identification of the causative agent, which, as regards occupational dermatoses, is important when considering prevention and rehabilitation. The traditional lists of accepted causative factors, already abolished in some countries, should be abandoned everywhere since they become obsolete due to the continuous change in the nature of industrial allergens.

To achieve an appropriate control of occupational dermatoses, good co-operation between dermatologists, industrial physicians and general practitioners is essential. Occupational dermatology, including the legal and social aspects, should be given more attention in undergraduate and postgraduate medical education, and the examination and certification of occupational dermatoses should be rationalized as much as possible.

Legislation on occupational diseases is one of the oldest forms of social security. In Great Britain, for instance, the first law on compensation for occupational diseases was enacted in 1897. Legislation still varies greatly from country to country, and even from state to state in the USA, in spite of the similarity of the problem all over the world. Therefore, it is not easy to propose a model for legislation on occupational disease for developing countries which are in great need of it. Moreover, national health services have been established in many countries, and they provide reasonable compensation for all diseases. This increase in social security is apt to decrease the importance of a special law for occupational disease in these countries. Thus, the

problem as to how occupational diseases are to be compensated has been raised even in the more developed countries. For these reasons the International Dermatitis Research Group decided to analyse the present situation concerning legislation on occupational diseases in a number of countries.

A questionnaire, the answers to which are presented in the table was sent to dermatologists in various countries who were known to be interested in occupational dermatology. Answers were obtained from, in addition to the members of the Research Group, W. Lindemayr and A. Raber (Austria), J. A. Oeffe (Belgium), J. Foussereau (France), K. Wereide (Norway), J. Fettich, A. Kansky and Zargy (Yugoslavia), and W. Burckhardt (Switzerland).

### *Historical and General Aspects*

Great Britain is the pioneer in legislation on compensation for occupational diseases, followed by the state of California among the countries represented in the present study. In most countries, including all of Scandinavia, the first laws date back to the period 1925 to 1935. Thereafter, the law has been changed quite recently in seven of the fourteen countries.

In general, these laws tend to include all employees, and there are usually no limits to the age of the insured.

Private insurance companies participating in the compensation of occupational diseases exist in only a few countries, the state system being the dominant one. Nevertheless, employers are obliged in one way or another to pay the premium; in Sweden it is included in the tax system.

Table I. Compensation of occupational dermatoses in 14 countries

Legislation year	Austria		Belgium		California		Denmark		Finland		France		West Germany		Great Britain		Italy		Netherlands		Norway		Sweden		Switzerland		Yugoslavia			
	1928	1938	1927	1968	1911	1913	1933	1959	1928	1968	1919	1946	1925	1968	1897	1946	1935	1965	1921	1967	1928	1969	1929	1954	1925	1963	1922	1965		
All employees included	-	+	+	-	-	+	+	+	-	+	-	+	+	+	+	+	-	+	+	+	+	+	+	+	-	+	+	+		
National insurance system for non-occupational diseases	-	-	-	-	-	-	-	-	+	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
All occupational dermatoses compensated	-	+	-	+	-	+	-	-	-	+	-	-	-	-	+	+	-	-	+	+	+	+	+	-	-	-	-	-		
<i>Restrictions in compensation:</i>																														
List of substances	-	-	-	-	-	-	-	-	+	-	-	-	-	-	-	-	-	+	-	-	-	-	-	-	-	-	-	-	-	
Relapses required	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Sick-leave required	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Change of work required	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Compensation for occupational aggravation of non-occupational hand-eczema	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Compensation for occupationally provoked eczema based on spare-time sensitization	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Compensation for house-wife's eczema	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
<i>Compensated costs</i>																														
Medical examination	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Medicaments	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Travel expenses	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Inability to work	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Lower income-change of work	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Rehabilitation	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Higher compensation than for other diseases	-	+	+	+	-	-	+	+	( <sup>c</sup> )	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Size of compensation for incapacity to work dependent on income	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Annuity due to partial disability	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Annuity (% based on normal working capacity)	20-40	10-40	10-40	10-40	( <sup>c</sup> )	10-40	10-40	10-40	10-30	10-30	10-30	20-40	20-40	20-100	20-100	20-100	( <sup>c</sup> )	( <sup>c</sup> )	<25	<25	( <sup>c</sup> )	( <sup>c</sup> )	10-100	10-100	( <sup>c</sup> )	( <sup>c</sup> )	<100	<100	<100	
Obligatory notification	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proportion of dermatoses to all compensated cases (%)	( <sup>c</sup> )	( <sup>c</sup> )	( <sup>c</sup> )	( <sup>c</sup> )	( <sup>c</sup> )	50	>50	>50	80	80	80	12	12	60	60	75	75	( <sup>c</sup> )	( <sup>c</sup> )	( <sup>c</sup> )	50	50	40	40	>50	>50	>20	>20	>20	

<sup>a</sup> Compensated through the public health service.<sup>b</sup> Housewives have the option of insurance cover within the framework of the legislation on occupational diseases.<sup>c</sup> Lack of information. <sup>d</sup> After 3 months.

In about half the countries considered here there is, in addition, a national health service. However, compensation for occupational diseases is mostly greater than that for other diseases. The only exception is in The Netherlands which has no special law for the compensation of occupational diseases, which are compensated according to the ordinary health service standards.

#### *Extent of Compensation*

In a few countries all occupational diseases are compensated, but in the majority there are some restrictions in the laws, as shown in the table. The most common restriction is a list of substances and other factors, considered to be contributory to such diseases. In Belgium and Finland, however, this list is not obligatory but, for example, in Finland a disease caused by any other occupational noxa is also compensated if an obvious causal connexion is medically established.

In some countries, such as Austria and Germany, relapse, sick leave and/or change of occupation, are a necessary requirement for compensation to be given.

The aggravation by work of a non-occupational dermatosis, such as hand eczema or allergic eczema based on a non-occupational sensitization, is compensated in most of the countries. In none of them is a non-occupational housewife's eczema compulsorily compensated according to the law. In Sweden, housewives have the option of insurance cover within the framework of the legislation on occupational diseases.

#### *Compensation for Various Expenses*

The costs of medical examination, medicaments and travel expenses are wholly compensated in most countries. The compensation paid for inability to work and for diminished income resulting from change of work is mostly lower than a normal wage, but is dependent on the level of income. In Belgium and Denmark the first fourteen days of incapacity are not compensated, whilst in Denmark provision is made through the national health service. In Sweden the expenses of the first three months of occupational disease are compensated through the national health system.

Permanent disability, even a partial one, because of permanent impairment caused by an occupational noxa leads to an annuity. It varies in

the case of lower incomes due to partial disability usually between 20 and 40%, varying slightly in different countries. It should be understood that the percentages do not give the exact level of annuity related to actual wages, since a 100% allowance does not equal the full earnings of the patient before disablement.

In most countries it is possible for the disabled worker to become rehabilitated through the insurance system, irrespective of whether it is governmental or private. It is, of course, necessary that the applicant should not be capable of performing his previous work and is suitable for rehabilitation, e.g. as far as age and other conditions are concerned.

#### *Decision on Compensation*

The procedure for a decision on compensation in individual cases varies greatly in different countries. In most of them the power of decision has been centralized in insurance boards or other institutions, irrespective of whether the compensation is covered by private companies, as in Denmark, or governmentally. On the other hand, there are countries where decisions are made separately by individual companies. A dermatologist is usually consulted, most commonly as a member of the central board. But in a few countries with private insurance companies the decision is often made without any dermatological opinion.

In all countries it is possible to appeal against the decision made.

In a few countries there are criteria for the compensation of occupational diseases or directives given by the authorities. In Denmark and Finland a special certificate is used for occupational dermatoses. In Finland this form is used not only for standardising the procedure but also for helping the doctor to examine the patient, which means that the form can also be used for case recording.

#### *Statistics*

In most countries there is a procedure for the notification of cases suspected to be of occupational origin by the employer and/or the physician. The statistics are often based on notified cases, but in Belgium on requests for compensation. In Finland and Italy the compensated cases form the basis of statistics, in Great Britain the



number of patients having been disabled, while in The Netherlands no statistics are available because compensation in all diseases, regardless of possible occupational etiology, is channelled through the public health insurance scheme.

### *Comment*

The most valuable asset of any nation is its labour force. Therefore, it is understandable that the first laws on social security were aimed at protection of employees. Although the majority of countries examined in the present study already have their national health systems, compensation for occupational diseases is higher than for other diseases.

It is of course, difficult to withdraw an established privilege, but by including occupational diseases within general health insurance, as has been done in The Netherlands, many inconveniences in the compensation procedure can be eliminated. However, the following points in favour of a different policy should be emphasized.

When a case of occupational dermatosis is compensated according to a special law the specification of the aetiological agent is essential, since otherwise it is difficult or even impossible to state that the case is to be compensated. And this is naturally of great importance to the patient. Thus, the law is apt to stimulate a search for the etiology of occupational dermatoses. The identification of the causative agent is important for many reasons, such as the following:

1. The successful treatment of any case of occupational dermatosis, such as contact dermatitis, presupposes knowledge of the etiology of the condition, in order to avoid contact with the causative agent.

2. Determination of the cause of occupational dermatoses also helps to plan protective measures for other workers in the industry involved.

3. When causes of occupational dermatoses are known, it is possible to collect information on them from different sources. This kind of statistic is important when planning the prevention of occupational dermatoses at the national or international level.

Quite obviously much more attention should be given to the prevention of skin disease by legislation and occupational safety regulations.

Not all occupational diseases are compensated,

originally probably to protect the insurance companies from being obliged to overcompensate at a time when such diseases were not sufficiently well known. Hence there are restrictive regulations in the laws of most of the countries. The most common is the list of substances and other causative factors which must be held responsible in order to warrant compensation. This list may be useful as a guide but quite obvious instances of occupational dermatoses are occasionally excluded if these lists are observed too strictly.

In most of the participating countries the decision procedure is centralized. The presence of a central institution or a centralized insurance board does not require that all insurance activities must be nationalized, but at least that the appeals board of experts should be centralized and made as efficient as possible. The most uneven results and the poorest legal security are found when there are many separate insurance companies, particularly if they do not consult a dermatological expert for their decisions. This kind of procedure cannot be regarded as justifiable at the present stage of development in occupational dermatology. However, such a system is now quite exceptional.

A disability is compensated by a temporary or permanent annuity. The limited annuity can vary greatly between separate insurance companies in the same country. Thus compensation for the same condition may not be equal for everybody. This drawback is eliminated or at least mitigated in countries where decisions are made by central insurance boards, which are able to accumulate the knowledge and experience required.

In some countries criteria are laid down for the compensation of occupational diseases. This is especially useful when no central insurance board or other corresponding bodies with the necessary expert knowledge have been established. But such specified criteria cannot replace a well organized central board with members from all the specialties involved in insurance medicine. The high incidence of occupational diseases of the skin makes the presence of a dermatologist on the board indispensable.

In most of the participating countries there is compulsory notification of cases suspected to be of occupational origin. This regulation is apt to increase the number of cases recognized. How effectively this notification system works in prac-

tice and how many cases remain undiagnosed is not known. The statistics in different countries are not comparable. It is even questionable whether the statistics in any country can be regarded as adequate. Hence the figures showing the part played by occupational dermatoses among all cases of occupational diseases should not be accepted too readily.

In the majority of the 14 countries the disabled worker can undergo rehabilitation under the insurance system. The process is slow and expensive. Therefore, when selecting cases for rehabilitation a particularly thorough dermatological and psycho-social examination of the patient is necessary, and it is highly desirable to ascertain the success or failure of the rehabilitated patients in their future occupations, in order to improve our knowledge of the indications for occupational rehabilitation.

#### *Recommendations*

In a special law for the compensation of occupational diseases, legislation must cover all employees. No upper age limit other than the normal retiring age can be justified.

If it is right to compensate all occupational dermatoses, regardless of cause, then the cause should be medically established. Pre-existing lists of accepted causative factors should be abandoned, because of continuous change in the nature of industrial allergens. Dermatologists should be given facilities to define the causes of occupational dermatitis as accurately as possible, especially where specific allergic sensitization is suspected.

Aggravation or provocation of allergic eczema in patients sensitized previously through non-occupational contact with the same substance should be compensated.

Even partial disability due to an occupational dermatosis should be adequately compensated.

Opportunities for rehabilitation are essential and particularly important for cases with a high degree of sensitivity to certain occupational allergens, or for cases with chronic irritant dermatitis of the hands.

More attention should be given to the prevention of occupational dermatosis. For its practical management, a precise and detailed diagnosis, including, as often as possible, identification of the causative agent, is essential.

In spite of defective statistics it is evident that occupational dermatoses comprise a majority of occupational diseases. Therefore, the presence of an "occupationally trained" dermatologist is a necessity for all decisions on skin diseases. In most countries this requirement has been fulfilled by a central insurance board composed of experts representing all the most important branches of occupational medicine, as well as technical and psycho-social specialists, for decisions regarding prevention and rehabilitation.

To achieve appropriate control of occupational dermatoses, good co-operation between dermatologists, industrial physicians and general practitioners is essential. Occupational dermatology, including the legal and social aspects, should be given more attention in undergraduate and post-graduate medical education; and the examination and certification of occupational dermatoses must be rationalized as far as possible.

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