

DIFFERENT LISTS OF OCCUPATIONAL DISEASES IN EUROPEAN UNION MEMBER STATES: IS IT A PROBLEM FOR THE LAW HARMONIZATION?

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Human health is seen as a public welfare, a fundamental good and even as a civil right [1]. Such a way of thinking results in that there is a will to ensure a high level of human health protection in the definition and implementation of all national policies as well as in coordination of activities of international organizations [2].

The European Union (EU) system concerning social security assurance treats the health insurance and the social insurance jointly (refers to full batch) [3]. According to a new approach to health determinants and strategies for health policy [4], EU Member States have decided to respect differences in the national health care systems and not replace various national social insurance schemes by a single common European system [3]. Measures of EU institutions designed to protect and improve human health exclude any harmonization of laws and regulations of the EU Member States [2]. At present, harmonization is not possible due to inequalities in standards of living within the EU. Moreover this situation arises from historical conditions and determinants sometimes dated from the 19th century. Even EU Member States with a similar level of living standards have quite different systems of social security (e.g., Beveridge's model in the United Kingdom,

the Bismarckian model in Germany), resulting from their long tradition consolidated in their culture. This raises the question of the objective of the unified health care system within the European Union. This would be contradictory to the principle of subsidiarity, which presumes the engagement of EU institutions only in issues not possible to be solved by institutions being closer to the citizens.

In other words, health care is a domain that lies almost exclusively within the competence of individual states. The role of EU institutions is limited to the coordination of social security systems operating in EU countries. Each Member State is self-reliant in deciding about the insurance coverage, the range of services, and the health care financial policy. The task of the European Union is to ensure that its Member States adopt legal regulations that do not entail adverse consequences for persons moving from one country to another [3].

Regulation No. 1408/71 of the Council on social security for the employees or self-employed persons, who were or are being subjects under legislation of one or several Member States and are citizens of one of Member States or "expatriates" or "refugees" being residents of one of Member States, and also members of their families as well

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as persons left after death of their main support consists of two primary principles:

- Synchronous subordination to legislation of only one Member State

- The insurance coverage in the country in which persons perform their professional activity [5].

European Union institutions also focus on prevention programs, health promotion and health education according to the Treaty Establishing the European Community (Amsterdam version) [6]. On the other hand, experiences of the recent years as well as new threats to health have contributed to some changes in the way of thinking about public health at the supranational level. A new public health formula presumes the implementation of EU policies of actions aimed at improving health quality of the European population [7].

The author analyzed the lists of occupational diseases being in force in the old and new EU Member States as well as EU regulations concerning occupational diseases. All materials essential to produce this paper were collected by the author during his study visit to the European Parliament in 2001 (the fellowship was founded by the Robert Schuman Foundation, Luxembourg and the Foundation for European Studies, Warsaw). The supplementary materials have been obtained due to the correspondence with some institutions relevant to occupational medicine in EU Member States.

Definition of occupational diseases and related problems.

One of the public health problems closely related to the principle of free movement of workers, which is one of the EU fundamental concerns [2], is an issue of insurance policies with respect to occupational diseases. The problem lies in the fact that each Member State has adopted not only its own list of occupational diseases, but also different criteria for recognizing and certifying them. Moreover, in individual Member States different definitions of occupational disease, work-related disease and accident at work still exist, which may lead to serious misunderstandings. The differences in definition mostly result from mixing two categories of diseases, occupational and work-related diseases. The occupational disease is a disease peculiar to an employee's

occupation, which develops due to causes in excess of ordinary hazards of employment as such [8], so it is a pathologic process by its etiology directly connected with work. On the contrary, the work-related disease is described as a disease, in which employment conditions are only one of the risk factors. This difference is very important in the context of insurance policies and compensations (sick benefits).

Common lists. At present there are two international lists of occupational diseases, one proposed by the International Labour Organisation (ILO) (amended at the Geneva conference in 2002) [9–13], the other established by the European Commission [14]. However, both of them can be only regarded as a recommendation (soft law) that legal regulations should be adopted by relevant bodies in individual Member States. There are also some binding regulations for EU Member States pertaining to occupational disease issues, but one uniform list of occupational diseases along with the criteria for their certifying to be respected by all Member States has not yet been developed, and each attempt to accomplish this important task encounters some difficulties in taking a political decision. This undoubtedly stems from rather complex social and economical situation. It is also true that the European Commission has not yet set criteria for recognizing occupational diseases even in a form of a soft law regulation. Whereas there is a growing need for developing such instrument, supported by the will of those involved in occupational health.

The list recommended by the European Commission is respected only in the Netherlands, where there was no list before. Belgium has a similar list [15]. The United Kingdom has two lists; one for statistical purposes, and the other is used to certify occupational diseases. Germany has its own original list [16] like Spain [17], Italy [18], and France; their lists have two sections, one contains the general register of occupational diseases, the other includes diseases related to occupations in agriculture. Sweden does not have any list of occupational diseases; physicians decide on each individual case whether the disease is supposed to be associated with the patient's professional activity. Other Member States also have their own lists, which are compatible only in some parts.

Some of the countries, which joined the European Union in May 2004 (e.g., Czech Republic), have established their list of occupational diseases compatible with the list recommended by the European Commission. In Poland, the new list was adopted in 2002 [19].

Consequences of differences between national lists of occupational diseases. A lack of one European list of occupational diseases in general, and uniform criteria in particular, respected by all EU Member States entails two adverse consequences:

- extreme difficulties in collecting epidemiological data on occupational diseases in the European Union;

- problems with recognition of occupational diseases in case of workers migrating between EU Member States.

Essential differences in the recognition of factors responsible for the development of individual occupational diseases in Member States confirm the opinion that comparisons of epidemiological data are not feasible. For example in Sweden, 70.9% of all diseases diagnosed in the years 1990–1992 were diseases of muscles and joints, whereas in Denmark this category of diseases made 35.9% of all diseases during the same period of time. The rates of hearing damage in those countries were 7.8% in Sweden and 20.9% in Denmark [20]. These differences result from the fact, that in one Member State some criteria are sufficient to diagnose an occupational disease, whereas in others they are not. Some diseases frequent in one country do not occur in another one [13]. Besides, the factors concerning the appearance of occupational diseases in general, in reference to the number of employed persons essentially differ among Member States [21].

The principle of free movement of workers entails the need to unify the rights and responsibilities of persons migrating within the social security attachment area, with those of persons being citizens of a given Member State. One can imagine problems in a situation, in which a person was employed in Member State A in conditions that caused a disease recognized in that state as an occupational one, and then moves to Member State B, where this disease does not occur. In consequence this person will not be compensated for suffering from the occupa-

tional disease, being under the legal and social insurance systems of the country, where he or she is currently employed. It is difficult to estimate the scale of this problem. However, there are two reasons for less pessimistic prognostication:

- the labor migration between UE Member States is relatively low: 0.5% of population per year [21];

- some categories of occupational diseases are single out on each list and there are only different criteria for recognizing them.

Conclusions. The final conclusion is, that establishing one European list of occupational disease would be useful for:

- monitoring and controlling occupational diseases in the European Union by collecting reliable epidemiological data. Collection of data would facilitate the development of common preventive programs;

- coordinating health insurance systems, according to the principle of free movement of workers.

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