ETUI Seminar on Covid-19 as occupational disease

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Contents

Covid-19 as an occupational disease in the UK

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Key points

- Covid-19 is not a prescribed occupational disease in the UK.
- The UK has a 'closed' list of prescribed occupational diseases meaning that a benefit claim can only be recognized for a disease on the list.
- Changes to the list of prescribed diseases are made by the Secretary of State for Social Security following recommendations by the Industrial Injuries Advisory Council (IIAC), an independent scientific advisory body.
- An IIAC position paper published on the 25 March 2021 concluded that the evidence is not, at present, sufficient for recommending prescription of Covid-19 as an occupational disease.
- IIAC will recommend prescription if and when (in their opinion) there is strong enough evidence that occupational exposures to Covid-19 cause disabling disease on the 'balance of probabilities'.
- Employers are legally required to report to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) scheme any incidents that led to, or could have led to, release or escape of SARS-CoV-2 virus or a worker dying, or diagnosed, with Covid-19 attributed to occupational exposure.
- As of May 2021 32,914 disease notifications of Covid-19 in workers where occupational exposure is suspected were reported to RIDDOR, including 392 death notifications.
- Other sources of data on Covid-19 in workers include death registrations and workplace outbreak investigations by Public Health England.
- Current government-funded research is investigating transmission of Covid-19 in the workplace.
- The Trades Union Congress are supporting union representatives in undertaking health and safety checks, encouraging RIDDOR reporting and advocating for worker payment during self-isolation, sickness absence and shielding for the extremely clinically vulnerable among other priorities.
- The current national debate is around mandatory vaccination for care workers which is opposed by the trade unions but not the general public. A recent court ruling paved the way for mandatory vaccination to be implemented but the government have not supported mandatory vaccination so far.

1. The Industrial Injuries Disablement Benefits Scheme

The UK differs from most EU countries in that reporting of suspected occupational diseases (OD) is not legally required for insurance or compensation purposes. The Industrial Injuries Disablement Benefits[1] (IIDB) Scheme provides non-contributory no-fault benefits for disablement because of an accident at work, or because of one of over 70 prescribed diseases known to be a risk from certain jobs. The benefit is tax-free and paid in addition to other incapacity and disability benefits. The list of prescribed diseases can be altered by the Secretary of State for Social Security following recommendations by the Industrial Injuries Advisory Council (IIAC), an independent scientific advisory body. The UK list of prescribed diseases is 'closed' meaning that only diseases on the list can be recognised for compensation. In contrast most EU countries operate an 'open list' which allows diseases not on the national list of occupational diseases to be recognised, usually subject to a higher burden of proof of causation.(1) The IIDB claim is mostly initiated by the employee, or their representative, and is not accessible to self-employed workers. Covid-19 is not currently a prescribed occupational disease so employees with Covid-19 attributed to workplace exposure cannot claim IIDB. They are entitled the same financial support offered to all workers with Covid-19 such as statutory sick pay or unemployment payments. In short the financial support offered to workers is the same regardless of whether the Covid-19 was contracted at work or elsewhere.

2. The Industrial Injuries Advisory Council position on prescription of Covid-19

An IIAC position paper[2] published on the 25th March 2021 concluded "*... the evidence is not at present sufficient for recommending prescription. However, the evidence of a doubling of risk in several occupations indicates a pathway to potential prescription and the Council expects that future data will enable a better understanding of the effect that Post-COVID-19 syndrome may have on loss of function. The Council will recommend prescription if and when there is strong enough evidence that occupational exposures cause disabling disease on the 'balance of probabilities.*'" IIAC will continue to monitor the literature for future published papers and reports of large, high quality studies of workers and workplaces, as well as community-based studies, focused on death from, and long term effects of infection with, Covid-19.

1. https://www.gov.uk/industrial-injuries-disablement-benefit
2. https://www.gov.uk/government/publications/covid-19-and-occupation-iiac-position-paper-48

3. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

Employers in the UK have a statutory requirement to report work-related accidents which cause death or reportable injuries, diagnosed cases of certain industrial diseases and incidents with the potential to cause harm to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)[3] scheme run by the Health and Safety Executive (HSE)[4]. The HSE is the UK government agency responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks. On the 10th April 2020 the RIDDOR reporting form was updated to allow for reporting:

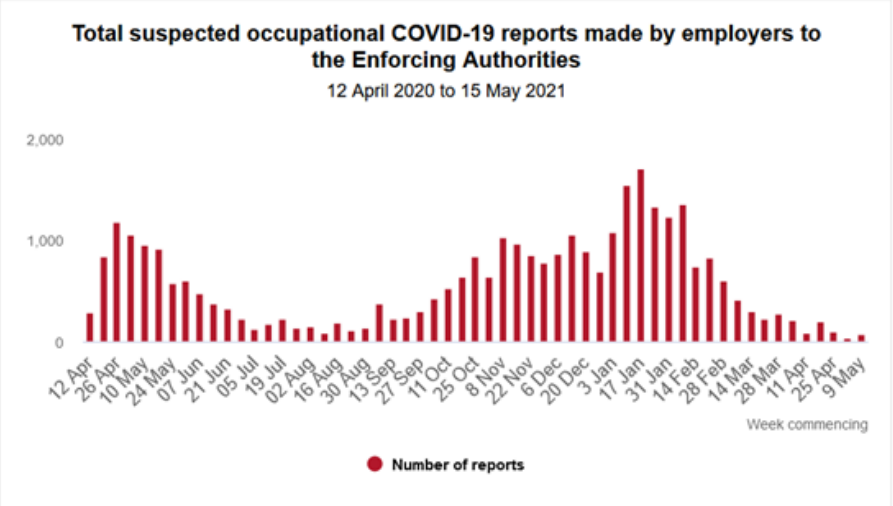
i. an accident or incident at work has, or could have, led to the release or escape of Covid-19. This must be reported as a dangerous occurrence.
ii. a person at work (a worker) has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus. This must be reported as a case of disease.
iii. a worker dies as a result of occupational exposure to coronavirus. This must be reported as a work-related death due to exposure to a biological agent.

The HSE provides guidance[5] on attribution to work, however it is ultimately a subjective decision by the employer. The guidance recommends consideration of whether work activities increased the risk of Covid-19 exposure, any incidents leading to exposure or contact with covid-19 without effective control measures or if a medical practitioner highlighted potential work-related risk factors.

From the 10th April 2020 to the 15th May 2021, 32,914 disease notifications of Covid-19 with suspected occupational exposure were reported to RIDDOR, including 392 death notifications (Fig 1). Around 70% of the notifications to RIDDOR were from the human health and social work sector. The others were mostly in the personal service sector (*e.g.* hairdressing and beauty treatment), physical wellbeing activities (*e.g.* laundering and dry cleaning) accommodation and manufacturing (particularly of food products but not beverages). The HSE acknowledge weaknesses in the RIDDOR reporting system; under-reporting[6] is a long standing issue but it isn't known if this is also the case for Covid-19 reporting. (2,3) RIDDOR reporting broadly follows the Covid-19 wider population trends and a more detailed breakdown of these data is available on the HSE website.

3. https://www.hse.gov.uk/riddor/
4. https://www.hse.gov.uk/
5. https://www.hse.gov.uk/coronavirus/riddor/riddor-reporting-further-guidance.htm#reasonable
6. https://www.hse.gov.uk/research/rrpdf/rr528.pdf

Fig 1. **Monthly reports of suspected occupational Covid-19 reports (taken from HSE[7])**



4. Death certification data

Another source of data on Covid-19 infections by occupation or industry comes from death certificates. The Office for National Statistics (ONS) has published three bulletins (April 2020[8], May 2020[9], December 2020[10]) reporting analyses of deaths for England and Wales involving COVID-19 by occupation. Using death as a proxy for infections is not ideal due to confounding by the variation in survival across occupational groups (according to demographic differences between workers in different occupations) and missing data, particularly for women. However there are few alternative sources of information. The highest adjusted death rates for men were in elementary occupations, caring, leisure and other service occupations, and process, plant and machine operatives. For women it was process, plant and machine operatives, and caring, leisure and other services.

5. The challenges in designating the attribution of Covid-19 to workplace exposure

The challenge in the UK, as in all countries, is distinguishing infections transmitted in the workplace from non-occupational circumstances. The case for prescription as an occupational disease rests on having robust research evidence on the causal probabilities. For most people Covid-19 is a self-limiting but about 1% will die and some will experience 'Post-Covid-19 syndrome' with 5% of people reporting

7. https://www.hse.gov.uk/statistics/coronavirus/index.htm
8. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020
9. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020
10. https://www.ons.gov.uk/releases/coronaviruscovid19relateddeathsbyoccupationenglandandwalesdeathsregisteredbetween9marchand28december2020

ongoing symptoms after one month and 2% after 3 months.(4) Currently the longer-term effects of Covid-19 are not well understood and there is no agreed case definition. So far it seems that Covid-19 due to occupational exposures is no more or less likely to result in Post- Covid-19 syndrome than non-occupationally transmitted Covid-19.

The main risk factors for infection with Covid-19 are having contact with an infected person(5), living in a household of more than 5 people or a care home, non-white ethnicity, living in a more deprived geographical location and being younger in age.(6) Clearly this reflects a mixture of circumstances that may, or may not, be work-related.

Although the relationship between workplace and non-occupational exposure is not yet well understood it is highly likely that some workplaces or workers will be exposed to higher levels of infection due to their job and workplace characteristics, and that this risk will vary with age, sex, location, and job role.

6. Guidance on control measures to prevent transmission of Covid-19

The HSE guidance[11] focuses on control at the source of the potential infection, e.g. isolation of infected people, restricted staff access, physical distancing, regular surface disinfection, ventilation and use of personal protective equipment (PPE). The British Occupational Hygiene Society (BOHS)[12] has developed a Risk Matrix[13] to provide practical guidance on the types of control measures that should be adopted to protect workers according to the likelihood and duration of exposure. The highest risk ratings are for care workers, and then 'public facing' workers with a high chance of face-to-face contact.

7. Investigation of workplace outbreaks of Covid-19

Public Health England (PHE)[14] is an executive agency of the UK government Department of Health and Social Care with responsibility for responding to public health emergencies such as Covid-19. PHE are responsible for investigating outbreaks of infectious diseases, including in the workplace. Most other workplace inspections will be undertaken by the HSE or union-appointed health and safety representatives who will report back to the HSE. During the Covid-19 pandemic PHE and HSE are working closely in investigating workplace outbreaks of Covid-19. When PHE identify a cluster of cases of Covid-19 in the workplace and declare a workplace outbreak (two cases with direct contact and no sustained community transmission)[15] the HSE will usually inspect the virus transmission controls and their implementation. Action will be taken in line

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11. https://www.hse.gov.uk/coronavirus/working-safely/index.htm
12. https://www.bohs.org/
13. https://mkobohsx5kak7rlajjs.kinstacdn.com/app/uploads/2020/10/BOHS-Covid-19-Control-Measures-Risk-Matrix-Version-1.0_23.07-1.pdf
14. https://www.gov.uk/government/organisations/public-health-england
15. https://www.gov.uk/government/publications/covid-19-epidemiological-definitions-of-outbreaks-and-clusters/covid-19-epidemiological-definitions-of-outbreaks-and-clusters-in-particular-settings#fnref:1

with the HSE enforcement policy if necessary. The HSE is leading one of seven studies as part of a national COVID-19 research programme[16] funded by the UK government. The HSE study[17] will address the transmission of COVID-19 in the environment, including in workplaces, transport and other public settings. The study is structured around five themes

1. Epidemiological surveillance of Covid-19 outbreaks and the associated risk factors in work settings(7)
2. Retrospective analysis of information recorded as part of regulatory investigation of two large Covid-19 outbreaks
3. Field studies to investigate the transmission risks of SARS-CoV-2 virus and their relative importance in causing the workplace Covid-19 outbreaks
4. Simulations to assess the population models developed to predict the probability of Covid-19 outbreaks in work settings, using data collected on human interactions individual and environmental risk factors of transmission and outbreak occurrences
5. Evidence synthesis on "what works" in controlling SARS-CoV-2 virus transmission in work settings

8. The role of trade unions

Trade unions play a vitally important role in the UK in making sure that workers understand their right to safety in the workplace. The UK Trade Unions Congress (TUC) in have published guidance to help trade union representatives[18] understand workplace issues in the context of Covid-19 and provide support in being effective in negotiating with employers to protect the health and safety of the workforce. The guidance focuses on issues around payment during self-isolation, sickness absence and shielding for the extremely clinically vulnerable, long Covid, home working, risk assessments (as mentioned above Union reps often undertake safety assessments and report back to the HSE), RIDDOR reporting of Covid-19, supporting bereaved workers, hygiene, PPE, ventilation in the workplace, face coverings and vaccination. The TUC recommends that nobody should feel forced to have a vaccine, nor should it be used as part of staff contracts or linked to pay. So far UK government policy has supported voluntary vaccination but the debate may be moving[19] towards compulsory vaccination(8), particularly for care home[20] and healthcare workers.(9) Vaccine hesitancy in the UK dropped substantially[21]

16. https://committees.parliament.uk/publications/3400/documents/32493/default/
17. https://press.hse.gov.uk/2020/11/04/hses-chief-scientific-adviser-welcomes-introduction-of-new-covid-19-research-programme/
18. https://www.tuc.org.uk/sites/default/files/2021-01/COVID-19GuideforRepsJan21.pdf
19. https://www.bbc.co.uk/news/uk-56750679
20. https://www.theguardian.com/society/2021/jun/02/uk-rights-watchdog-endorses-compulsory-covid-jabs-for-care-home-staff
21. https://www.ipsos.com/ipsos-mori/en-uk/vaccine-confidence-grows-month-month-latest-ipsos-mori-knowledgepanel-poll

between January and March 2021 and 56% of the public surveyed supported mandatory vaccination for adults[22] in January 2021. The union for care workers[23] has strongly opposed mandatory vaccination for care workers.

9. Short answers to the questions asked by this report

1. Are there any cases in your country where Covid-19 is recognized as an occupational disease? *No, Covid-19 is not yet recognized as an occupational disease in the UK.*

2. In which sector, activity, geographical area or company was Covid-19 recognized as an occupational disease? Are there any limitations to the recognition? *Covid-19 has not been recognised in any sector.*

3. What impacts the recognition has on the employee, on the employer, and on the insurer? *Not relevant as Covid-19 is not recognised as a prescribed occupational disease nor is recognition linked to insurance, it is a tax-free benefit paid directly by the government.*

4. What measures are applied to the situation when an employee is infected at work by the virus and develops the Covid-19 disease? *If PHE deem a workplace outbreak to have occurred (two cases of Covid-19 with a direct contact between the individuals and no known community transmission) then PHE will investigate the outbreak and the HSE may be involved. If a report is made to RIDDOR it will be recorded and may be investigated by the HSE.*

5. What is the current national discussion on this issue? *Prescription of occupational diseases is not often debated in the public domain in the UK, possibly because compensation is rarely awarded and requires significant disability plus the amount of money is relatively small. The recent IIAC position paper prompted some debate in a BBC radio programme "File on 4" – "*The Cost of Long Covid*"[24]. The current debate in the public domain is around mandatory vaccination, particularly in care workers.*

22. https://www.ipsos.com/en/global-attitudes-covid-19-vaccine-january-2021
23. https://www.gmb.org.uk/news/care-worker-mandatory-vaccinations
24. http://downloads.bbc.co.uk/rmhttp/fileon4/PAJ_2707_PG02_Long_Covid.pdf

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COVID-19 as an occupational disease in Bulgaria

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Introduction

In Bulgaria, since the beginning of the pandemic of COVID-19 until now (31.05.21), 418274 people have been infected with the virus and the death toll is 17662. The country went through two periods of sharp rise in incidence - in November-December 2020 and March-April 2021. Hospitals were overcrowded during these periods and medical professionals were at their limits, under constant stress and strain from the large influx of patients. The shortage of adequate precautions was palpable. In this complex situation, those working in the Covid wards were true heroes, deserving of recognition for their work and the risk they take every day to save lives.

The work of medical professionals during the pandemic is a typical example of occupational risk. The working week of these employees was not subject to any requirements for normal working and resting patterns. To compensate for the work of those who were on the front line in the fight against the disease, the state provided an additional EUR 500 a month on top of the salary, which is still being paid. Vaccination of those working on the front line began at the end of December 2020.

The average age of nurses in Bulgaria is over 55, while that of doctors is over 58. This automatically puts health care workers in an at-risk group with an increased risk of contracting COVID-19. Since the beginning of the pandemic, more than 13 thousand medical professionals have fallen ill and 120 deaths have occurred among them. So far, none of these cases have been recognised as an occupational disease. It is the same situation in all other professional sectors in the country.

In recent years, the number of recognised occupational diseases in Bulgaria has been decreasing year by year. According to the National Social Security Institute (NSSI), in the period 2009-2018, a total of 308 cases of occupational diseases were registered in Bulgaria (Table1). It is interesting to note the fact that in 2009 the number of registered cases of occupational diseases was 116, and in the following years the number of cases decreased dramatically, reaching levels of 15 to 30 cases per year. This data suggests problems in the system of recognition of occupational diseases. The general impression is that, in general, for occupational diseases in Bulgaria, neither the employer wants to be detected, nor the worker goes to claim his/her rights until he/she retires because of fear of losing the job.

Table 1. **Registered occupational diseases in Bulgaria 2009-2018**

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Occupational diseases	116	41	29	14	15	22	28	33	15	15

Bulgarian legislation for occupational diseases

According to the Bulgarian legislation, an occupational disease is a disease that has occurred exclusively or predominantly under the influence of harmful factors of the working environment or the work process. The procedure for the recognition of an occupational disease starts with the submission of a prompt notice on a form of suspicion of the presence of an occupational disease. This notice is completed and sent by a medical or dental practitioner to the territorial division of the NSSI and the employee's place of work. In turn, NSSI appoints an examination of the case, which aims to consider the factors of the working environment and the work process under which the person worked, as well as any other data that would help the medical examination to confirm or reject the occupational nature of the illness. This examination involves a representative of the NSSI, a specialist in occupational medicine, a representative of the Labour Inspection Directorate and representatives of the employer and the employees. The sick person or his/her representative may also be present. Confirmation or rejection of an occupational disease is carried out by the Territorial expert medical commissions (TEMC), which are appointed by order of the Minister of Health, and by the National Expert Medical Commission (NEMC), which acts as the final instance in the event of an appeal against the decision of TEMC. These commissions must include specialists in occupational diseases and occupational medicine. Within 3 months of receiving the documents from the examination, TEMC decides on the nature of the disease - occupational or general. An expert decision is issued, which can be appealed by the persons concerned before NEMC. The duration of the expert decision recognising an occupational disease is up to 3 years, after which the person must be re-certified.

Recognition of COVID-19 as an occupational disease

COVID-19 is not included in the list of occupational diseases in Bulgaria, but can be recognized as such on the basis of Article 56 (2) of the Social Insurance Code. It states that a disease not included in the list of occupational diseases may also be recognised as an occupational disease if it is established that it was caused principally and directly by the insured person's usual occupational activity and it caused temporary incapacity for work, permanently reduced work capacity or death. Despite the fact that it is regulated by law, including confirmation by a directive of NSSI to its territorial subdivisions, there has not been a single case of COVID-19 recognised as an occupational disease in Bulgaria.

According to NSSI, only cases with laboratory-confirmed COVID-19 infection by PCR test, regardless of clinical symptoms, are subject to a rapid notification. Unconfirmed cases where laboratory testing is inconclusive or unavailable are returned for correction of the indicated deficiencies. The ICD-10 code "U07.1 COVID-19, virus identified" is used to code the disease. The prompt notice should be sent by the personal physician. An epicrisis from the actual Covid ward where the employee was admitted as a patient, may also be submitted. Declarations of an occupational accident in a COVID-19 case will not be considered. A notice explaining the procedure for reporting cases of COVID-19 as a suspected occupational disease will be sent to the employer and the ill person.

Any laboratory-confirmed PCR test cases of COVID-19 in Bulgaria will be reported to the Regional Health Inspectorate (RHI). In return, RHI takes action to investigate the patient, isolate or hospitalize him/her at its discretion, identify his/her contacts, set up an organization for their laboratory testing, and introduce and control anti-epidemic measures. The sick person must notify his/her personal physician and is placed in 14-day quarantine in a home environment if hospital treatment is not necessary. Once the quarantine has expired, the general practitioner issues a sick note for temporary incapacity for work for the period, which the sick person is to present to their employer. In this respect, the provision of information on the results of the survey carried out by the RHI should also be required to prove the occupational relevance of a case to COVID-19.

Over 120 people in the health care system have died from COVID-19 and its complications and it is statistically impossible that none of these cases have an occupational link. Having worked in a Covid ward or directly with infected patients in hospital structures such as an emergency department, imaging department, etc., the occupational risk is there to be acknowledged in any case and the lack of such acknowledgement is astonishing.

Current national discussion on the issue

The topic of COVID-19 as an occupational disease is hardly touched upon in the public domain. There have been political confrontations and prolonged protests against the backdrop of the pandemic crisis in Bulgaria. There was a demonstrative disagreement among professionals about the measures being taken to combat the virus. The media space was filled with information about business problems, measures against the coronavirus and daily statistics about the situation in Bulgaria and around the world. There is a lack of solidarity during such a major health, social and economic crisis.

Trade unions have received complaints about dismissals during illness. There is a reported case in which a trade union inspection showed the following sequence of facts: healthcare workers have requested the employer to file a rapid notification for an occupational disease. This was in response to their refusal to be paid the EUR 500 promised to frontline workers. This money was refused because the employees were absent from work during the working month. Following this refusal, the employees are uniting and saying that they will ask all workers who

have been ill since the start of COVID-19 to submit claims for recognition of occupational disease. This situation does not come to that because the employees reach an agreement with the management and the case ends.

Trade unions in Bulgaria are calling for a strengthening of social dialogue, including an increase in the capacity of the General Labour Inspectorate, which is the supervisory body for compliance with the Occupational Safety and Health Act. In the words of Alexander Zagorov (occupational safety and health specialist and confederal secretary of Podkrepa CL), prevention should always be the main focus in the fight against COVID-19. Updating workplace risk assessments is important for choosing appropriate measures to protect workers.

Currently, Bulgaria has a caretaker government due to the impossibility of forming a new cabinet after the elections held in March this year. This caretaker government cannot pass laws. Its main task is to organise new parliamentary elections, which must be held on 11th of July. Meanwhile, working life in Bulgaria is gradually returning to its pre-pandemic state. Many people are returning to their jobs after a prolonged period of working remotely. Strict adherence to anti-epidemic measures is crucial to control the spread of COVID-19. Especially now occupational health services have more than ever the important task of helping to ensure that adequate measures to protect against the virus are properly introduced and implemented in the workplace.

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A reporting study for Covid-19 as an occupational disease in Greece

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Abstract

Occupational accidents and diseases are regulated by the Greek Social Insurance System. Occupational Disease (OD) reporting is made by the occupational medicine specialists towards the inspection state department supervised by the Ministry of Labour. The recognition procedure is long and complicated, involving investigative, medical and legislative phases. Finally, a temporarily authorized medical state committee does or does not approve, the definition "occupational" to the reported disease.

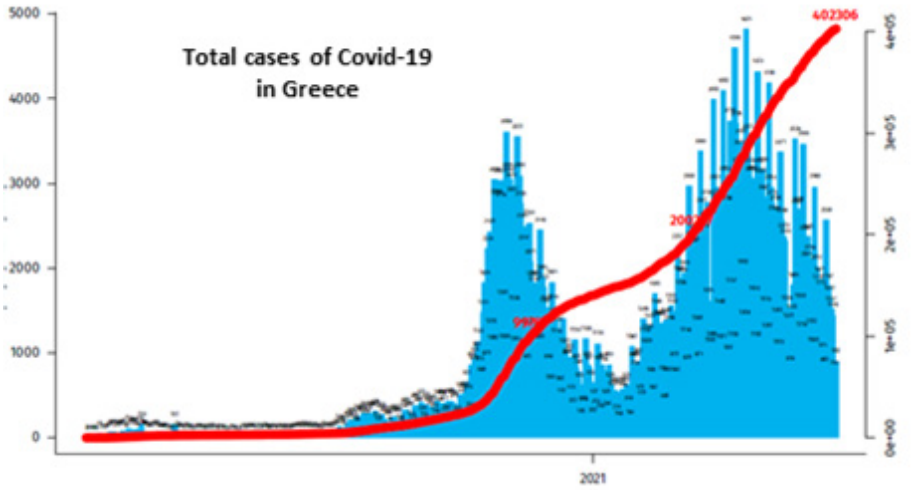
In Greece, none of the 402.306 recorded cases of Covid-19 is defined as an occupational one, until the date of the present report. Although severe acute respiratory syndrome (SARS) from Coronavirus is enlisted in the Greek catalogue of occupational diseases since 2012 and the SARS-CoV-2 virus was recently classified in the "Risk Group 3" of hazardous biological agents, there are not any official records for occupational cases of Covid-19. The lack of occupational health services in the majority of Greek workforce allows all relative issues to be underestimated.

Currently, every employee once a week is obliged to undergo the Covid-19 self-testing procedure and to report the result in a web based state platform. Unfortunately, the social insurance system compensates the absence from work due to Covid-19 only to hospitalized workers. The time for self-isolation of a worker who was infected or had a close contact with an infected person, is hardly indemnified.

Although SARS-CoV-2 viral infection will be soon classified in the official list of occupational diseases, Greece has many limitations to overcome in order to establish a successful system of OD notification and recognition, not only for Covid-19, but in general.

Recorded cases of Covid-19 in Greece

Pandemic Covid 19 in Greece is exclusively monitored by the National Organization of Public Health (EODY in Greek), supervised by the Ministries of Health and Civil Protection. Until the end of May 2021, 402.306 cases of COVID-19 and 12.095 associated deaths have been recorded by EODY[1] and officially confirmed by the Greek Ministry of Health, as demonstrated in the figure below.



Although most of the infected people (about 75%) aged between 18 and 64 years' old, as presented in the following table, none of COVID-19 cases has been recognized as an occupational disease by the Greek Ministry of Labour[2], until the date of the present report.

Age	Total cases of Covid-19	Associated Deaths
Total		
0 – 17	34432 (8.7%)	3 (0.0%)
18 – 39	134986 (34.0%)	86 (0.7%)
40 – 64	164986 (41.5%)	1871 (15.5%)
65+	62920 (15.8%)	10135 (83.8%)
Men		
0 – 17	18250 (9.0%)	1 (0.0%)
18 – 39	71462 (35.2%)	68 (1.0%)
40 – 64	83309 (41.0%)	1279 (18.3%)
65+	30077 (14.8%)	5643 (80.7%)
Women		
0 – 17	16180 (8.3%)	2 (0.0%)
18 – 39	63518 (32.7%)	18 (0.4%)
40 – 64	81661 (42.1%)	592 (11.6%)
65+	32837 (16.9%)	4492 (88.0%)

Unofficially, healthcare workers, policemen, school teachers and customer clerks belong to the most affected occupations during the second wave of Covid 19 pandemic in Greece, according to recently web published articles nationwide[3-9].

On the other hand, there are not any official records for cases of Covid 19 in relation to their occupational origin in Greece, despite the recommendations of EUROSTAT from the beginning of the pandemic. Furthermore, no medical report or worker's complaint has been officially registered for SARS-CoV-2 infection due to occupational exposure[2].

In Greece, the recognition criteria of eligible occupational diseases are regulated by the social insurance system and they are based on a closed catalogue model with specifically enlisted diseases[10], legislated in 2012, in compliance with the European Community Recommendations 2003/670/EC. According to this national list of occupational diseases, Covid-19 can be eligible for recognition, in case there is a severe acute respiratory syndrome (SARS) due to Coronavirus infection.

Limitations to the OD recognition

Apart from classifying any disease to this corresponding occupational list, there must be a case-by-case investigation of causal relationship, between hazardous exposure and the reported health disorders[11]. The latency period, the spatial adequacy and the dose-response relationship of exposure are taken into consideration. Furthermore, common non-occupational causes need to be ruled out, like inheritable diseases, hobbies, lifestyle and other social factors. Periodically, a medical state committee[12] is temporarily constituted in order to investigate all of the reported cases.

Unfortunately, occupational health issues in Greece are usually underestimated, so is Covid-19. The services of occupational physicians are obligatory only for companies with fifty or more employees, according to the national law 3850/2010[13]. Consequently, there are not any occupational health services provided in the majority (87%) of Greek workforce[14], usually occupied in small enterprises with personnel less than fifty workers. In addition, another limitation is the lack of specialized doctors in occupational medicine (less than two hundred) in Greece[15] and the absence of OD clinics in public hospitals. The low number of occupational medicine specialists in Greece, led the Ministry of Labour to allow physicians with different medical specialty to provide occupational health services. Since 2005, about five hundred doctors (less than 400 now active)[16] have been authorized to act as occupational physicians and have been registered by the Ministry of Labour. All the occupational health providers are authorized to report any suspected diseases with an occupational origin. General practitioners and other clinicians are usually more focused on curative aspects and report less cases of occupational diseases than the occupational medicine specialists, who are very familiar with control measures and administrative procedures. Moreover, the fact that very few occupational medicine experts provide their services to public hospitals is another strong limitation for the reporting of Covid-19 in the most affected workgroup population, the health care workers.

Procedure and impacts of the OD recognition

The OD reporting doctor has to fill and send a form to the occupational inspectors' state department (SEPE in Geek), supervised by the Ministry of Labour. When the OD report is officially announced, a very long-term procedure follows in order the Greek State to evaluate the worker's health status and to investigate the working conditions. The occupational inspectors of SEPE have the authority to carry out autopsies, make interviews and collect documents in order to provide evidence for any causal relationship among the occupational exposure and the reported disease. At the same time, the regional director of the social insurance operator is responsible for the registration of the reported occupational disease. After confirming the insurance of the employment, the OD case is referred to the insurer's headquarters in Athens, where the authorized medical committee for occupational diseases is exclusively active[12]. This committee will thoroughly evaluate the correspondence of the reported disease to the national list of occupational diseases, based on every document or evidence provided. The evaluation procedure includes a documentary, a medical and a legislative phase. When the definition of OD is decided, both the insurer and the employer are obliged to provide all the concluded requirements[11,17].

In case the reported disease is defined as an occupational one, then the affected worker receives specific benefits. Firstly, all relative medical and pharmaceutical expenses are fully covered either by national insurance operator or by the employer. Secondly, an uninsured employee can be compensated according to the degree of his working incapability due to the occupational disease. Finally, a sickness allowance is granted to the affected worker for the whole period of his incapability, a part of which is contributed by the national insurer and the rest by the employer. In case of a serious (over 50%) permanent disability18 the worker is entitled to request an early retirement and a national pension subsequent public fund.

Occupational control measures for Covid-19

During the first wave of the pandemic, the State of Greece applied a lot of control measures in order to reduce the risk of Covid-19 transmission in public. Many high risk enterprises had to lock down but hospitals were strengthened. Specific vulnerability criteria were established and high risk workers were suspended for at least one month, compensated by the employer. Technical unemployment, remote-work or work-from-home was officially regulated for public and private workplaces with social distancing, mask wearing and a lot of other technical and administrative safety measures.

By the second wave of the pandemic, the SARS-CoV-2 infection had been widely spread all over Greece and thousands of Covid-19 cases were revealed. In December 2020, a presidential decree[19] included the SARS-CoV-2 virus in the "Risk Group 3" of biological agents which can cause serious illness in humans and pose a serious danger to workers.

In contrast to this high risk classification, every infected worker was authorized to return at work after a ten days' quarantine, without providing any serious evidence of full recovery or negative antigen test results. The same official instructions are given via phone calls by the local representatives of Civil Protection Ministry, until today.

At the end of April in 2021, the State of Greece established the self testing procedure for all workers through a web based state platform[20], with the weekly obligation of a personal negative self test. When a positive self test is reported, work is postponed and a second rapid test within 24 hours is appointed to a state health care facility. If the second test is also positive, the worker is instructed for 10 days' self-isolation at home. If the second test is negative, the worker receives a medical certificate and returns to work. Every employer has to be informed about the results of all personnel every week. A fine of 500€ may be imposed to an employee who did not declare the result and 1500€ fine per worker, for the employer respectively.

Theoretically, each infected worker is entitled to be compensated for the whole sick leave duration after providing a medical certificate of Covid-19 with a positive antigen test attached. In fact, only hospitalized workers due to Covid-19 are being compensated, while the asymptomatic or mildly sick ones isolated at home do not receive any compensation, as the respective ministry regulations remain unclear and the controlling authorities are well excused. Eventually, the financial burden of occupational absenteeism due to Covid-19 is exclusively carried by the employers.

Current national discussion

As mentioned above, occupational health services in Greece are inadequately provided, due to national legislation. Less than fifteen percent of the total workforce nationwide is precautionary examined by occupational physicians. The vast majority of Greek workers and employers are not familiar with the terms of occupational medicine and occupational disease.

Furthermore, occupational health services are totally absent or poorly provided to the most affected by Covid-19 workgroup populations, such as health care workers, school teachers, transportation drivers, sales workers, social services etc.

During the last decades, Greek trade unions are vigorously fighting for the recognition of many hazardous occupations as "heavy and unhealthy" in order the exposed workers to receive a specific employment allowance. The minimization of occupational risk and the enhancement of healthy workplaces is not a trade unions' priority in Greece. One serious complaint was though announced by the public workers' trade union (ADEDY in Greek) accusing the fact that there are no official records for Covid-19 cases in relation to their occupational origin, in Greece. Additionally, the trade union demanded the recognition of Covid-19 syndrome as an occupational disease.

Since the beginning of the pandemic, the national institute of health and safety at work (ELINYAE in Greek) hosted a series of web based conferences21 in order many high risk occupational sectors to be adequately informed.

Nowadays, there are also many published complaints by Greek economists and successful accountants, who recommend for every worker with medical certificate and positive PCR antigen test to be at least recognized as a common case of Covid-19 disease and to receive compensation for the recommended sick leave duration.

Recently the Minister of Labour announced the possibility of amending the national list of occupational diseases by including the Covid-19 infection. “Since the virus SARS-CoV-2 is recognized as an occupational hazard, the insurance of relative risk at work must be regulated”, was officially stated.

Apart from legally recognizing Covid-19 as an occupational disease, many problems have to be solved in order to actually protect all exposed workers in the future. In fact, about ten cases of occupational disease are totally recognized in Greece per year, but relevant data remain unpublished in annual reports of SEPE[20]. The lack of occupational medicine specialists in combination with the absence of occupational disease clinics should be firstly regulated. Secondly, the obligation for occupational health services should be widened and include the majority of Greek workforce and not only the enterprises with 50 or more workers (68% are occupied in companies with less than 9 employees and 19% in companies with 10-49 employees)[14]. In parallel, the occupational inspectors’ force should be upgraded with more staff, advanced equipment, better software and quick plan of actions. Finally, the notification and recognition procedures for occupational diseases should be simplified and shortened in period of time.

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Covid-19 as an occupational disease in Finland and points of interest in national debate

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Finland recognizes Covid-19 as an occupational disease (OD), like any other biological factor. The recognition includes full compensation of income losses and treatment needed. This far (April 2021) we have accepted 304 cases out of 355 suspected ones. One OD patient has died.

There are no geographical nor sectoral limitations to the recognition as OD, but vast majority of the cases have been presented in health care sector. A positive Covid testing (usually PCR) result is needed, as well as an identified exposure (close contact) at work prior to the diagnosis of the infection.

National discussion includes distribution of vaccines and protective equipment, as well as rights of migrant workers or evidence needed for suspected cases of long Covid. In addition to the infection itself, the psychosocial effects of the pandemic are significant for many sectors and increase the burden for workers.

The definition of an occupational disease is specified in the Workers' Compensation Act 459/2015

All employers in Finland must insure their employees against accidents at work and occupational diseases. Students making their practice are also covered by the Act. **Private insurance companies perform a public duty** and provide these compulsory insurances as regulated by **Workers' Compensation Act 459/2015**. This Act in chapter 6 defines the basic criteria for diseases accepted as an OD. Occupational disease refers to an illness that is **likely** to be **primarily** caused by the employee's **exposure to a physical, chemical or biological agent** at work. For an illness to be substantiated as an occupational disease, a **medical examination** with sufficient information available on the employee's working conditions and verified exposure at work is required. **Occupational Health Service** helps with information concerning the exposure when needed. These common principles are also valid for Covid-19 cases and have been so starting from the very beginning of the epidemic. So, there was no need for specific new legislation when the pandemic started, since Covid cases were covered immediately and could be recognized as OD.

In Finland we also have a listing of chemical, physical and biological agents in the **Decree** (VnA 769/2015) on Occupational Diseases to be annexed to the regulation provided by the Act 459/2015. There in the Decree we have no specification of Covid, but that means no problems considering compensation mechanisms since **the list of ODs is not exhaustive but indicative**.

Workers' Compensation Centre (TVK) is a Central organization gathering together all the Companies serving in the field of statutory work accident and occupational disease insurances. It works for the implementation and development of the Occupational Accidents, Injuries and Diseases Act. It works on a **tripartite basis** and all the insurance institutions operating in Finland must be members. Tasks of the Center include, among others, supervising the insurance business and helping to keep the decisions just and equal for all insured workers. It also offers statistics on accidents at work and occupational diseases.

Benefits provided by the compulsory insurance

There are **no geographical nor sectoral limitations** to the recognition of Covid-19 as an OD. There is no monetary limit on the amount of compensation nor, in most cases, time limits on compensation. The benefits include (in most cases) the full **loss of income**, full compensation for **medical and other costs** and expenses, plus medical and vocational rehabilitation if needed. A compensation also covers for death, including a pension for surviving family members.

The insurance for accidents at work and occupational diseases takes precedence over other social security benefits.

Self-employed persons may voluntarily take out and pay for personal insurance against occupational accidents and diseases, which is identical to the compulsory workers' compensation insurance for employees. For example, part of health professionals at private clinics work as self-employed persons and have chosen not to take a voluntary insurance.

Proceedings to accept Covid-19 infection as an occupational disease

The source of infection needs be traced to work or workplace. No worker, not even in health care sector, is accepted to have been infected at work unless the Insurer is informed there has been a **close prior contact** with a Covid-positive person.

When a possible OD case arises, suspected due to presented symptoms or recognized exposure, there is a need to get a **verified positive test result** from the worker to present it to the Insurance Company. The test may be repeated if first negative and further clarification is needed. Home-made tests are not accepted for insurance purposes. Testing for Covid (usually PCR) has been easily available in Finland after the very first weeks of pandemic in spring 2020. Testing is free

of charge for all suspected cases and offered as a part of public health services. Testing in Occupational Health Services may also be possible. Those tests are paid by the Employer.

Both the worker affected by Covid, and the Employer need to fill in a **Notice for the Insurance Company**, explaining there has been a verified exposure at work prior to the positive Covid-testing. Spaces like dressing rooms or workplace cafeteria also might be considered as possible places of exposure. Thus, the source of infection may be a **patient, a client or a colleague.** Known incubation period of 1 to 10 (upto 14) days is expected. You should also give information concerning possible exposure during your leisure time. For example, a prior Covid case at home (spouse or child) is usually (but not always) considered to be a more likely source of transmission than a contact at work.

Once the Notice with adequate information is sent to the Insurance Company and the Covid-positive worker claims for compensation, **the process itself is not complicated** and the decision with payment should be made **during 30 days**. Probably not all the workers with mild symptoms and enjoying paid sick leave send the Notice for their Insurance Company nor apply for the benefits, though the transmission might be work-related. A slight underreporting of the true OD cases is possible.

Tracing of contacts is usually done by the public health services. The occupational health services may help and participate if there are cases and possible transmissions at work environment. **In the beginning of April 2021 there were 304 verified cases of Covid-19, confirmed as an occupational disease**. Part of the Notifications is received with some delay, meaning statistics are getting updated with possible delays as well. Suspected cases were 355 until April 2021. **90 % of all the accepted cases were presented from social and health care sector**, registered nurses and practical nurses being the biggest professional groups. There has been only one verified OD case of a patient who passed away, and that case was outside health sector.

Finland has been fighting the pandemic quite effectively and is not among the most heavily affected countries in terms of Covid-19. Our population is 5,6 million, and up to May 25th 2021, there were 91 740 verified cases. Since testing is easily available and strongly encouraged throughout the country these numbers are estimated to reflect the actual situation relatively well. All reported death cases sum up to 942 by that date.

Challenges and points of discussion

During the first weeks of pandemic in spring 2020, there was some shortage of testing kits and personal protective equipment. Consequently, some OD Covid-cases may have not been able to get a verified diagnosis. For those situations, some help and benefits are provided even through **Infectious Diseases Act** (1227/2016) which guarantees free treatments for patients with generally hazardous infectious disease (like Covid-19). The same Act regulates for full compensation for income

losses, but only during an officially ordered **quarantine or isolation** if they are needed to control a generally hazardous infectious disease (like Covid-19). In situations other than officially ordered quarantine and isolation The Social Security Institute Kela offers Covid patients the same **sickness benefits (daily allowances)** as for any other disease. Daily allowances cover 70 % of the salary at the highest, thus offering a considerably lower level of compensation for income losses than the accepted cases of OD. **Collective Agreements** may include other benefits like full pay for sick leave (usually 2-3 months), or additional curative Occupational Health Services.

High percentage of **teleworking**, mostly from home, is one of the reasons behind relatively low numbers of Covid in Finland, both generally and as an OD. Practically all Finnish employees holding official or clerk positions have been teleworking since March 2020. The estimated percentages vary between 42% up to 59% of the working population in different surveys, and are considered to be the highest in Europe. On the other hand, **only around 10% of blue-collar workers** affiliated in Unions of SAK told that they have been able to perform any remote work at all. **These workers continue being vulnerable to virus** since they face contacts (clients or colleagues) at work on daily basis.

Workers in many sectors have also suffered **psychosocial strain** when being afraid to get the virus at work, possibly passing it on to their families including persons identified as risk groups. This has been a reality for workers in the health care sector, but widely also other public and private services. There has been discussion whether some professions should be prioritized in the **distribution of vaccines**, but finally only personnel for Covid patients and persons themselves included in risk groups were classified as a priority to get the vaccination. All other population and professions are being vaccinated by age groups, descending order. Mental problems associated with Covid infection cannot be compensated as an OD.

Migrant workers are most numerous at construction sites or seasonal agricultural jobs. There have been a few local infection clusters at those workplaces. Probably the coverage of Occupational Health Services, adequate information about preventive and curative services, testing and right to insurance compensation have not reached all these workers. Language problems or feeling unsecure about their position may result in not willing to send the required Notice for suspected OD. Naturally, they will then not get the insurance benefits they might be entitled to when insured under the Finnish social security legislation. There may be other obstacles as well, like if the transmission is estimated to have taken place in shared housing facilities and not directly at work, the Covid-case is not classified as an OD. Trade Unions have made their best in order to inform these workers and help them know their legal rights.

One point for concern is the compensation for possible **long covid-cases**. The development and background factors for this condition are still incompletely known, and the Insurance Companies may seek how to cut the payments down if the experienced disability to perform work is prolonged. More research in this field is needed and welcomed. There are only a few long covid cases this far accepted as OD in Finland and no pensions this far.

Since there is an increasing number of proof that the **airborne transmission** (not droplets) is important and new, more virulent variants are emerging, we might consider re-evaluating the criteria ("close contact") for compensation and ease the recognition of Covid cases as OD in the future.

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COVID-19 as an occupational disease in Malta

Dr Luke A. Fiorini

Are there any cases in your country where Covid-19 is recognized as an occupational disease? In which sector, activity, geographical area, or company was Covid-19 recognized as an occupational disease? Are there any limitations to the recognition?

In Malta, COVID-19 has not been formally listed as an occupational disease. In order to be formally recognised as an occupational disease, diseases need to be listed in the fourth schedule of the Social Security Act (Chapter 318, Laws of Malta). The Director of Social Services may however entertain submissions from individuals who have developed diseases that are not listed in the schedule but are believed to have developed as a result of their work. This is not believed to have occurred so far with COVID-19.

COVID-19 is seen primarily as a public health concern and thus relevant legislation and enforcement falls under the Public Health Act (Chapter 465, Laws of Malta). In view of its potential for transmission within workplaces, both between external visitors/clients and employees as well as between different employees, the CEO of the Occupational Health and Safety Authority (OHSA), Dr Mark Gauci, highlighted during a radio interview (KSU, April 2021) that COVID-19 was seen as a potential occupational disease and thus whilst it was primarily legislated as a public health concern, employers were required to protect workers from this hazard as per the Occupational Health and Safety Authority Act (Chapter 424, Laws of Malta). It is worth noting that whilst physicians are encouraged to notify the OHSA of occupational diseases (it is not a legal requirement), such notifications are received very infrequently; subsequently, statistics on the prevalence of occupational diseases in Malta are not published.

Identified cases of COVID-19 are reported during press conferences by the Superintendent of Public Health. Initial press conferences held during the first wave of COVID-19 were carried out daily and provided detail on transmission, including clusters within occupational settings. These included diverse sectors such as transportation (e.g., ferry, airport), healthcare stings (hospitals, homes for the elderly), and hospitality, amongst others. Such press conferences were discontinued once numbers dropped, but were re-instated once the frequency of new cases peaked during a second wave. Press conferences however were less frequent than during the first wave, whilst the information provided was also more restricted. The number of cases identified within occupational settings was however highlighted during these press conferences. An official database of such trends is not published publicly.

What impacts does the recognition have on the employee, on the employer, and on the insurer?

In Malta, an individual who develops a disease as a result of their work may be entitled to compensation via the social security system. Individuals who suffer from an occupational disease and are unable to work may be eligible for up to a year of 'injury leave' on full pay, less the amount of any 'injury benefit' the person may be entitled to (the term used is because the same leave is used for occupational injuries). Workers can be denied this benefit if found to have contravened the employers' safety rules or contributed by means of their negligence. Conversely, benefit paid to the worker by the Social Security can be claimed from the employer by the Director of Social Security if it is proven that the said employer breached the provisions of the Occupational Health and Safety Authority Act. Where occupational diseases result in permanent loss of physical or mental abilities, such workers are entitled to 'Injury Grant' or 'Injury Pension' (which is received depends on the degree of the impairment – those with lesser impairments receive the Injury Grant, whereas those with greater impairments receive the Injury Pension. Individuals determined to have 90% impairment or more receive neither of these, but instead receive an Invalidity Pension). Widows of husbands who die as a result of an occupational disease may also be entitled to a pension, with the amount dependent on the care and custody of children. Furthermore, pensions are provided by the Social Security to pensionable parents or parents incapable of self-support when the person maintaining them dies as a result of an occupational disease.

In terms of COVID-19, two alternative leaves are instead being utilised. Since the onset of COVID-19, the government introduced a new form of special leave entitled 'Quarantine Leave'. This applies to employees ordered to quarantine by the Superintendent of Public Health, or other authorities. When an employee tests positive for COVID-19, workers are to use sick leave. Workers who were quarantined as a precaution, but then develop COVID-19, shift from Quarantine Leave to Sick Leave. Should, once sickness ends, the worker need to remain in quarantine, Quarantine Leave is made use of once again. Workers on Quarantine Leave receive their full wage for the duration of the quarantine order; this is paid for by the employer, who can apply to receive a grant provided for each full-time employee that was placed in mandatory quarantine. Conversely, sick leave entitlement varies by sector and depends on various Work Regulation Orders. In many areas, workers are entitled to their full wages for two working weeks per year. In terms of this sickness benefit, employers pay the first three days of any sickness period in full, whilst from the fourth day a 'Sickness Benefit' is received from the Social Security Department. Thus, from the fourth day an employer can either pay the difference between the Sickness Benefit entitlement and the employee's wage, or the employer can pay the wage of the employee in full and then is refunded the amount of the Sickness Benefit by the employee once it is received. Where sickness exceeds the legal period, employers are no longer obliged to pay for sick leave and workers continue to receive the Sickness Benefit offered by the Social Security Department to which they may be entitled.

In terms of the insurer, the grant to employers for the Injury Benefit for those with an occupational disease, and the Sickness Benefit given during sick leave

are provided by the state's Social Security Department. In terms of the Sickness Benefit, single individuals or those married who's spouse is working receive €13.73 per day. Married individuals whose spouse is not working receive €21.21 per day. In terms of the Injury Benefit, single individuals (and those with working spouses) receive €23.94 per day, whilst those married and their spouse does not work receive €31.82 per day. In terms of quarantine leave, this is administered by the Malta Enterprise, with employers eligible to receive a grant of €350 per employee.

As workers with COVID-19 are not making use of Injury leave, but rather of Quarantine Leave and Sick Leave, there is the potential that a worker who is no longer infectious but develops incapacitating long-COVID symptoms could initially remain with limited support should they exceed the period covered by their sick leave. Furthermore, such workers may find it more difficult to apply for relevant pensions or for their dependents to receive cover in the event of their death. It is not excluded that such workers could obtain occupational benefits as the Director of Social Services may consider submissions from such individuals. No such cases are known to have occurred and the situation is considered complicated as the applicant may find it difficult to prove that the disease was in fact due to occupational transmission.

What measures are applied to the situation when an employee is infected at work by the virus and develops the Covid-19 disease?

When a positive case is detected, individuals are contacted by the state's 'Case Management' team which informs them that they are to quarantine and compiles a database of individuals who have been in contact with those who are positive. Where those positive have attended a workplace, the organisation may be contacted to aid in the compilation of this database. The database compiled by Case Management is then used by the 'Contact Tracing' team who call those in the database, including family, social contacts and work colleagues.

Guidelines for dealing with COVID-19 in the workplace are issued by the Ministry of Health, these include the prevention measures to take in several work sectors, as well as the measures to take when faced with a COVID-19 case. Primarily, employers are advised to isolate workers who develop COVID-19 related symptoms and to call public health for advice. Typically, if symptomatic these will be invited to take a COVID-19-related test and may be asked to isolate until the results are received. In the case of a positive case, the measures to be taken in the workplace will depend on the results of a risk assessment, typically conducted via telephone by the Public Health contact tracing team. Measures may include requesting contacts undertake a COVID-19 detection test, placing workers on preventative quarantine, or allowing work to continue normally. The criteria for this choice are not publicly available. Where in a workplace it is suspected that a COVID-19 cases has occurred (or if it is confirmed), the health department states that cleaning and disinfection should take place. Guidelines on how to clean and disinfect workplaces are provided by Public Health. In view of Malta's very high

prevalence of micro organisations, the quarantine of a few workers can sometimes result in organisations being closed down for this period of quarantine. Larger organisations are more resilient in this respect.

In terms of the enforcement of COVID-19-related regulations, this is conducted by various groups including the police, officers from the Local Enforcement System Agency (LESA), Transport Malta, the Malta Tourism Authority, the Armed Forces of Malta (AFM), and environmental health officers.

What is the current national discussion on this issue?

The topic of COVID-19 as an occupational disease has not been a topic of national discussion. The only examples of this being discussed was an August 2020 newspaper article by a fellow of Malta College of Family Doctors calling for COVID-19 illness acquired by healthcare workers to be classified as an occupational disease.

Most national discussion around COVID-19 has primarily revolved around the provision of wage supplements for those industries severely impacted by the pandemic, and calls for certain sectors to be closed in view of their risk (or to be opened again by individuals who have an interest in such sectors).

COVID-19 AS AN OCCUPATIONAL DISEASE in Ireland (Republic of)

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1. Introduction

The present situation is that Covid-19 is not recognized as an occupational disease (OD) in Ireland but this is under review. Ireland has an open and closed list system. It was recommended in an EU Commission report that SARS CoV-1 could be diagnosed as an occupational disease[1] but this was never prescribed as an occupational disease in Ireland under the closed list system (prescribed disease). There is a Private Member's bill before parliament at present sponsored by the main opposition party which has passed the 2nd stage[2].

The Health & Safety Authority (HSA) is looking at the classification of Covid-19 as an OD and has convened an expert report to advise their Board on classification; so far it has not been classified. The ratification process is not as structured or clear as other countries' including the UK Industrial Injuries Advisory Committee[3] doubling of epidemiological risk of the job, exposure and disease triad. If HSA expert committee's Regulatory Impact Assessment (RIA) does recommend Covid-19 be classified as an occupational accident or disease then it would require to be ratified by the Minister of Social & Family Affairs under S.I. No. 102/2007 - Social Welfare (Consolidated Occupational Injuries) Regulations 2007[4].

There may be a policy preference to have infected workers to process their claims through the civil (negligence proof standard) courts and many worker claims have already been filed but these can take years to hear and settle with significant financial and economic cost in terms of workers getting back to work and getting on with their lives. Data linking 'long COVID' to workplace exposure is likely to present difficulties as it is not yet as defined compared to a 'case' or 'death'. Post-COVID impairment may fall outside such a scheme should one emerge as at the present time the usual sick pay terms are not in action for absence associated with COVID 19 disability in the public sector. The incidence of post-COVID syndrome is estimated at 10–35%, while for hospitalized patients[5] it may reach 85% perhaps prompting the biggest area for litigation.

There is a lack of comprehensive epidemiological data on occupational Covid-19 infections either to the HSA for accident and dangerous occurrence reporting for Covid-19 as occupational death, or accident or illness.[6] The Safety, Health and Welfare at Work Act 2005 (2005 Act)[7] sets out the key preventive obligations for employers trying to combat accidents and ill-health in the workplace. Under the 2005 Act, personal injury includes any injury, disease, disability, occupational

illness, impairment of physical or mental condition or death. The obligations relating to reporting of accidents to the HSA is dealt with in the Safety, Health and Welfare at Work (General Application) (Amendment) (No. 3) Regulations 2016 (2016 Regulations). Under the 2016 Regulations, diseases, occupational illnesses or any impairment of mental condition are not reportable to the HSA. This position was re-stated by the HSA in May 2020 when it issued guidance for employers and employees about the health risks presented by COVID-19. The Irish Congress of Trade Unions (ICTU) recommended that the legislation be amended to re-introduce an occupational illness notification requirement. Consequently, the Safety, Health and Welfare at Work (Amendment) Bill 2020 was published with the aim of amending legislation to make incidences of COVID-19 notifiable to the HSA.

There are specialist physician reporting schemes through THOR Ireland (SWORD, Epiderm, OPRA and THOR GP Ireland) and data from the Department of Social Protection for payment of Covid-19 enhanced Illness Benefit[8], Coroner reports are another potential data source but have not been collated yet, Public sector employers have special leave with pay for attendance in workplace within 14 days of diagnosis with Covid-19 but there is no central collation of this data. Finally as Covid-19 is a reportable infection under the Health Acts 1947 and 1953; Infectious Disease Regulations 1981 and subsequent amendments to these regulations[9] and data has been collated for certain occupations such as Health Care workers (HCWs)[10]. Also the quarterly Labour Force survey from the Central Statistics Office (CSO) has self reported non-medically validated data.[11]

2. Are there any cases in your country where Covid-19 is recognized as an occupational disease?

Answer- not presently, it is under consideration by our National Health & Safety Regulator, 'the Health & Safety Authority' who is carrying out a RIA. This is the normal process observed for any significant legal change. No special or emergency procedures have been put in place for such processes in light of the pandemic.

3. In which sector, activity, geographical area or company was Covid-19 recognized as an occupational disease? Are there any limitations to the recognition?

Answer- it has not been prescribed in any economic sector, job or work activity, nor geographical area or company.

Given the significant numbers of workers infected, the question whether 'long COVID' is an OD or a problem for the nation at large is clearly important. There are a wide array of questions. From an occupational health perspective, it brings an opportunity to focus on an individual's daily function, workability, and engagement in work in order to promote good health and productivity. When return to work

is not feasible, public sector workers already have access to employer Injury or incapacity allowances and possible application for public sector pensions benefits. However workers in the prívate sector or more precarious employment may have difficulty getting the support they need to get back to work.

4. What impacts the recognition has on the employee, on the employer, and on the insurer?

This is the subject of a RIA which is ongoing. The call to recognise 'long COVID' as an occupational disease raises a number of important questions: how to define 'long COVID', what level of symptom severity and duration of symptoms to include, whether objective tests are a requirement, and what relative attributions and 'burden of proof' is required to indicate and /or confirm an occupational link. If there is compensation for any injury, illness or death which was caused by service, this will require some test of attribution. During a rise in COVID-19 community cases it is possible to argue that COVID-19 was acquired outside the workplace and there is some evidence for this from early HCW studies[12]. It is possible that employers will need to consider reporting and monitoring systems to capture cases amongst workers in order to compare this to community infection rates. However, Trade Unions have reported that some employers have been reluctant to acknowledge that any infections could have arisen from an occupational setting, and are maintaining that community infection is the "default" and predominant mode of infection for workers.

The Irish government have expressed concern that classifying Covid-19 as an "occupational illness" – where incidences in work would have to be reported and investigated – could have serious consequences for both employers and the State in terms of liability[13]. Concerns have been raised that some Trade Unions were pushing for the move on the basis that it would require the HSA, a State body through which workplace injuries are reported to investigate every workplace notification of Covid-19. In some economic sectors, Trade Unions called for outbreaks of Covid-19 in a workplace to be investigated by the HSA to establish if that workplace had breached the guidelines given for re-opening safely. There is a tension between a comprehensive health & safety risk assessment approach to Covid-19 prevention in the workplace and following Public Health Guidelines that don't necessarily incorporate a full integrated hierarchy of control measures as required under the Biological Agent Regulations[14].

Where the nature of the work poses an occupational exposure health risk to COVID-19 such as in healthcare and laboratory settings, employers are required to ensure that an appropriate Biological Agents risk assessment is carried out. Suitable control measures should be identified and implemented to mitigate the risk of COVID-19 infection. Risk assessments need regular review and updating and must be based on current best practice in relation to infection prevention and control.

5. What measures are applied to the situation when an employee is infected at work by the virus and develops the Covid-19 disease?

Answer: If a worker is told to self-isolate, restrict their movements or diagnosed with COVID-19, they can apply for a COVID-19 enhanced Illness Benefit payment[15].

Both employees and self-employed people can qualify for the COVID-19 enhanced Illness Benefit. Public sector workers can get 'Special leave with pay for COVID-19' which applies when they are advised to self-isolate and are displaying symptoms of COVID-19 or if they had a positive test. Appropriate medical/HSE confirmation of the need to self-isolate and/or a diagnosis of COVID-19 is required[16]. Special leave due to COVID-19 (positive case and self-isolation purposes) is not counted as part of the employee's sick leave record. In certain circumstances, special leave with pay for COVID-19 may continue to be paid beyond 28 days provided you meet the specific criteria[17]. See HR Circular 005 2021 Updated DPER FAQs re Working Arrangement and Leave associated with COVID-19. However, such provisions do not typically exist in the private sector where there has been a variety of employer responses.

6. What is the current national discussion on this issue?

The report has already referenced the Regulatory Impact Assessment of designating Covid-19 as an OD. This was instigated several months ago but is still in process. As mentioned the main opposition party has introduced a Bill to have Covid-19 so designated, arising from demands from the Irish Congress of Trade Unions for such a change. This is currently going through the parliamentary process. The parliamentary committee overseeing this legislation invited submissions and evidence from the ICTU, which supported the proposal to have Covid-19 classed as an OD, and from both the HSE (Health Service Executive; the public health manager) and the HSA, both of whom essentially gave evidence that they regarded the current arrangements for reporting of Covid1-19 as a communicable disease to be adequate. The results of the RIA may impact on the progress of the Bill, but it is unlikely to have government support.

The risk reduction guidance for HCWs at risk of covid infection or Health Protection Surveillance centre Public health guidance took limited account of relevant past research and precautionary guidance in their recommendations to reduce exposure to the virus. They ignored evidence or guidance existing prior to the pandemic, such as from the Health and Safety Executive (HSE)(UK)[18], European Centres for Disease Control[19], Federal Devices Agency/Centres for Disease Control (USA)[20] or from previous SARS coronavirus or similar outbreaks[21], and which would have mandated respirators (e.g. FFP3) as Respiratory Protective Equipment (RPE) for jobs such as front line healthcare and social care workers who were likely to look after infected patients. As was noted early in the pandemic[22] scientists had the evidence based foresight in 2008 to show the suitability of FFP3 respirators

and the inadequacy of 'surgical masks' to protect against viral aerosol. There were forewarnings that the widespread use of respirators might be difficult to sustain during a pandemic unless provision is made for their use in advance.

Pandemic policy appears to have been influenced by a need to "rationalise the rationing"[23] of such personal protection. In the context of frontline staff an example of this was the presumption, essentially lacking objective evidence, that the main or only risk of airborne exposure to HCWs arose from so called 'Aerosol Generating Procedures' (AGPs) such as tracheal intubation, bronchoscopy and artificial ventilation of patients. National public health guidance (rightly) advised the wearing of fitted filtering facepiece respirators (e.g. FFP3) for such exposures. Yet then it only provided for 'surgical masks' in the routine face to face care of infected patients who were exhaling airborne virus while coughing, talking and even breathing (in spite of the prepandemic precautionary guidance cited above).

Risk management should be constantly updated based on new and emerging evidence and the shortcomings are not simply those evident 'with the benefit of hindsight'. The greatest concern in primary prevention of covid-19 at work has probably been the persisting underestimation of the risk of airborne spread and need for precautionary protection, in spite of past lessons. The Irish Public Health Guidance was weaker than that of the European Centre for Disease Prevention and Control [11] which, in February 2020, stated that the minimal composition of a set of personal protective equipment (PPE) for the management of suspected or confirmed cases of covid included (as RPE) a FFP2 or FFP3 respirator (valved or non-valved version), with face masks to be used 'in case of shortage'.

All employers have a legal responsibility to make a "suitable and sufficient" risk assessment in respect of all employees. "The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work." Few would argue other than that the pandemic risks were so high, and the nature of frontline work so critical that detailed and comprehensive assessments were warranted. For employers to merely say that they were 'following national public health or HSE guidance' does not constitute a risk assessment. Moreover the public health guidance provided inadequate protection relative to the guidance antedating the pandemic or the current medical, scientific and professional consensus[24].

As explained the Irish Government has not thus far responded formally to the call for any compensation scheme or to ratify the disease as an occupational disease. As noted the Safety Health & Welfare at Work, (General Application)(Amendment 3) 2016 Regulations[25] currently present a "loophole" for employers to avoid reporting COVID-19 clusters to the HSA in a bid to avoid inspection, publicity or possible liability. The government has been asked to clarify whether further amendments will be made to the existing legislation to include COVID-19 as a reportable occupational illness given there is an immediate, exceptional and manifest risk posed to public health by the spread of the virus. However, arguments have been put forward that employers cannot reliably ascertain whether when faced with a diagnosis of COVID-19 in a worker, if the virus was contracted in the workplace or was community acquired. Concerns exist that any legislative amendment could

lead to substantial employer liability. Data protection issues have been cited on the basis that employers would be obliged to share an employee's sensitive personal data with the HSA. In March 2021, the Spanish Government recognized COVID-19 as an OD among HCWs infected on duty. Similar steps have been taken in European countries, such as Germany, Belgium and Denmark. Any such ratification, in Ireland would most likely be limited to those front-line, key workers in the healthcare sector. It is speculated that this is likely to be the outcome of the ongoing RIA. In the meantime, contraction of the virus as a result of an employer's breach of statutory duty or common law duty of care could provide an employee with a claim for damages, irrespective of whether Covid-19 has been classified as an OD. Causation, legal and medical, is complex and will need to be very carefully assessed.

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Recognition of Covid-19 as an occupational disease in Sweden

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Occupational diseases can be recognized for compensation in two different ways in Sweden

A. By law and compensated by the social welfare system
B. By a collective agreement between unions and employers and compensated by an insurance[2].

A. Recognition by law

Recognition by law is regulated by the "Social Insurance Code"[3] (2010:110). An occupational injury by the law (caused by accident or disease) includes in Sweden no list of diseases that can be recognized as occupational in contrary to most other countries. A general requisite for an occupational injury is that there should be predominant reason for a causal relationship. However, for contagious diseases there is an exception in a regulation (1977:284). Contagious diseases can only be recognized

1. for persons who work in laboratory with the contagious agent
2. for persons who work in hospitals, health care, or other caring of persons (e.g. in nursery homes) of persons if they during that work has got the infection (and there is a list of infections e.g. tularemia that can be compensated).

Rather early during the pandemic the regulation was changed for group 2 to also include Covid-19 (April 25th 2020).

Compensation from the state and regulated by law includes compensation for loss of income for the worker and pensions to widow/widower and children if the worker has deceased. The administration is somewhat different for the worker and for widow/children and is described separately below.

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2. Persons employed by the state are directly compensated by the state but the compensation is the same as if it would be given by the insurance company
3. https://www.riksdagen.se/sv/global/sok/?q=socialf%c3%b6rs%c3%a4kringsbalk&st=1

A worker who consider she/he has an occupational disease shall report it to the employer who reports it to the Swedish Social Insurance Agency (SSIA, Försäkringskassan[4]). There are digital and paper formulas. A copy of the report is sent to Swedish Work Environment Authority (SWEA) which has a register of the reported/notified cases.

The compensation for compensating the worker is administered by SSIA. It decides if the disease should be compensated and pay the compensation. It consists only of loss of income due to decreased work ability due to the disease/accident. SSIA only investigates if there are reasons for compensation if the decreased work ability due to the disease/injury will last for at least one year. That means that mostly the investigation starts after the disease is still causing decreased income due to decreased work ability after a year. Thus, in most cases the workers with an occupational disease have the same sick leave benefits as the person would have with any other disease/injury for the first year of the disease. Furthermore, the regulation state that after 180 days of sick leave, the work ability should be assessed not only to the workers present job but to any normal job in the Swedish labor market. In several cases, the sick leave after 180 days is regarded as unemployment and the person will be given unemployment benefits if she/he do not find a new job . It is unclear if there yet has been any such cases due to Covid-19. However, if there is a medical certificate that the work ability will last for at least a year the SSIA may start an evaluation if the disease is occupational.

The economical compensation for loss of income due to sick leave will be higher for occupational diseases and covers full compensation for loss of income up to a certain salary. Compensation to the person due to an occupational disease according to the law will end when the he/she is 65 years of age.

Pension can be paid to *relatives to deceased persons with occupational diseases*. It is paid by the Swedish Pension Agency. The assessment to decide if the death is caused by an occupational disease is done by SSIA. For a deceased person SSIA starts the evaluation as soon there is a request from the Swedish Pension Agency. The latter requires that the family of the deceased worker had notified the Agency about the death and asked for pension. Otherwise, there is no assessment of a possible occupational origin of the cause of death. Only deaths below 65 years of age is evaluated and compensated.

Thus, there are several obstacles before a disease will be classified as an occupational disease and compensated by law, and especially during the first year after the disease has appeared. I.e. if a disease caused by occupational exposure cause work ability for less than a year it will mostly neither been investigated, compensated or recognized as occupational by the law. Since most cases with Covid-19 will survive and be fit to work within a year, there will be no investigation from SSIA if the sick leave is caused by an occupational disease that could be compensated.

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4. www.forsakringskassan.se

Evaluated cases with Covid-19 according to the law

Cases with Covid-19 evaluated by SSIA until March 15th 2021 in Sweden has been summarized by a governmental agency[5] (Inspektionen för Socialförsäkringen/ The Swedish Social Insurance Inspectorate). Only one worker was evaluated for decreased work ability and loss of income after one year due to Covid-19. It was a newspaper man and the case was not recognized as an occupational disease. The person had Covid-19 in April 2020. SSIA dismissed 58 other cases diagnosed between March and December 2020 as SSIA assessed that the persons would not have loss of income (>1/15) one year after the diagnosis. For such cases there is no evaluation if the sick leave is caused by an occupational disease (or occupational injury).

There were 18 deceased persons assessed by SSIA of which five were accepted as occupational diseases. The 18 persons died between March 2020 and June 2020. The occupation of the 13 cases that were dismissed are listed in table 1. All accepted cases worked in health care of patients.

Table 1 **Occupational titles among deaths that was dismissed by SSIA as caused by Covid-19.**

Occupation	N
Bus drivers	4
Engineer	1
Warehouse worker	1
Cleaner	1
Delivery of post/parcels	2
Project manager	1
School worker	1
Taxi driver	1
Sports coach	1

So far there is no case of an occupational injury that has been evaluated according to the law[6]

Review of the law

The government[7] asked ISF (March 18th 2021) to evaluate if the law about occupational disease/injuries should be changed so more occupational groups/ situations could be entitled to compensation for Covid-19. The evaluation lists different changes in law that would increase the group but recognize also problems with the changes. To skip the special regulation that classify certain jobs as entitled would lead to difficult evaluations. The general approach in the law that

5. https://isf.se/publikationer/skrivelser/2021/2021-04-26-arbetsskadeforsakringen-och-covid-19
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the predominant reasons that the disease should be caused by work is difficult to prove when the contiguous agent is rather common both in and outside the workplace. A special regulation for Covid-19 means that other contagious should be handled in a similar way or that e.g. it could be easier to be compensated for Covid-19 than for e.g. Ebola or tuberculosis. The evaluation lists several options but give no one priority. The chief physician for assessing occupational diseases in the SSIA has similar views of the possibilities and problems7.

Notifications to SSIA by persons who consider themselves having an occupational disease caused by Covid-19

The employers should report an injury notified by a person to SSIA. Statistics about notifications are handled by SWEA, while statistics of cases evaluated by SSIA is handled by SSIA. There was a very rapid increase in notifications in 2020, Table 2.

Table 2. **Number of reported cases of Corona-19 as occupational disease, February 2020 – April 2021[8]. (Reported to SWEA/SSIA)**

Month	Year	
	2020	2021
January		2855
February	1	3421
March	2	3288
April	166	2454
May	1047	
June	2133	
July	1340	
August	592	
September	769	
October	763	
November	1135	
December	2162	

B. Recognition by a collective agreement between unions and employers

About 90 percent of Swedish employees are covered by collective agreements which provide compensation for occupational diseases and injuries. The agreements are between unions and employers´ associations. An employee is included if the employer is associated to the insurance independent of whether the worker is a member or the union. Self-employed persons have to take out the insurance themselves if they want to be covered.

8. Personal communication Kjell Blom SWEA (2021-05-19)

The insurance is administrated by company owned by Sweden's labor market parties. (www.afaforsakring.se). The insurance covers loss of income if not covered by the governmental insurance according to law describe above, disability benefits, extra costs for care, inconveniences etc. Occupational injuries are covered from the first day, while diseases are covered if they last for more than 180 days. Furthermore, they should be accepted by SSIA or the disease should be on a list (ILO-list from 1980 is used in the agreement). The list includes infectious diseases provided that they have occurred in health or laboratory work including other types of caring of people, veterinary work, work handling animals, animal carcasses, parts of such carcasses, or merchandise which may have been contaminated by animals, animal carcasses, or parts of such carcasses, or other work carrying a particular risk of contamination. Thus, for Covid-19 the criteria are similar to that by the law, but compensation can be rewarded if there are e.g. disability or decreased work ability after 180 days. A few cases caused by Covid-19 have been accepted in persons working in health care or similar sectors. The decision to compensate is determined by the staff in the insurance company. However, for cases with Covid-19 and not an approval or a clear rejection by the staff, the board for the insurance has indicated that it wants to take the final decision. The board consists of representatives from unions and employers´ associations[9].

The insurance also covers compensation for relatives if the worker dies. The insurance is valid up to the age of 65 years. The person who claims compensation from the insurance must notify the insurance company. It is not automatically transferred from the notification according to the law (see above). So far (middle of May), around 5000 persons had notified AFA insurance that they have got Covid-19 due to their work. It is today unknown how many of them that still have symptoms after 180 days.

So far there is no notification that claim that the cause of Covid-19 is an occupational injury (caused by an “accident”). When I ask what could be such case a possible sequence of events is a policeman that has been infected by bite from a person who the policeman is going to seize.

Comments

The criteria in the two systems for compensation of occupational diseases are rather similar when it comes to decide if Covid-19 is an occupational disease. For cases occurring in hospital care or other types of care of persons the assessment is fairly straightforward. For workers that are infected during transportation in buses, taxis etc. there is so far no recognized case and it will probably be hard to find out that there are predominant reasons that the infection occurred in the job and not during spare time. Anyhow, both the agreed collective insurance and the government are aware of the problem, but there is no change in law/agreement yet and no suggestions are on the table as far as I have found out.

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9. Personal communication Michel Normark (2021-05-20)

My view is that there probably will not be a change in the law to include a larger group. The evaluation by ISF showed obvious problems and few solutions. The collective agreed insurance can be changed to include more persons that can be compensated, but I have no idea if that will be the case.

Due to the criteria for compensation there will probably be rather few compensated living cases by the law (Type A) during the next few months as the law requires that the disease cause work impairment and loss of income for more than year. If post-Covid-19 will be a common diagnosis and cause of long-term sick leave it will probably be uncertainties around the diagnostic criteria rather than criteria for occupational exposure that may determine if a case will be compensated as of original origin. There will probably be more compensated cases in the collective agreed insurance, due to a shorter lag time between infection and compensation (180 days).

Compensation for relatives to deceased workers will probably be compensated according to the criteria for exposure in both the law and insurance which are similar.

Since the occurrence of serious Covid-19 infections seem to decrease due to vaccination and better medical treatment, the biggest future issue will if post-Covid-19 will be an established diagnosis.

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