ETUI Seminar on Covid-19 as occupational disease

National reports
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Covid-19 as an occupational disease

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SPAIN

Begoña Martínez-Jarreta, PhD

Spain is one of the European countries hardest hit by the COVID-19 pandemic. According to data from the Spanish Ministry of Health, confirmed cases in Spain to the date of the present report (12.01.2021) total 2,111,782 and associated deaths exceed 50,000\(^\text{1,2}\). In fact, the Spanish Monitoring System of Daily Mortality (MoMo) recently estimated that the number of COVID-19 associated deaths could reach over 80,000 in 2020 (MoMo report of 30 December 2020)\(^\text{2}\).

Among the population groups most affected by COVID-19 are healthcare workers (HW)\(^\text{3}\). During the first wave of the pandemic they had to cope with severe shortages of personal protective equipment\(^\text{4}\). In Spring 2020, Spain became the EU country with the highest percentages of such professionals affected by COVID-19\(^\text{3}\) and their occupational exposure to SARS-CoV-2 has been a serious concern since the beginning of the pandemic.

According to Ministry of Health data, from March to May 2020 (first wave of the pandemic), 22% of cases notified to the SIVIES (Spanish Surveillance System of the National Centre for Epidemiology) corresponded to HW, with a significantly higher rate among women than men (29.1 vs. 11.7%) (76% of healthcare personnel with COVID-19 are women)\(^\text{5,6}\). However, data for 10 May to 29 December (second wave of the pandemic) shows a different scenario, with a significant reduction in the percentage of cases among HW (4.6% of cases notified with 6.9% women vs. 2.1% men). This decrease could be due to the general improvement in preventive resources and particularly health professionals’ personal protective equipment\(^\text{7}\).

Although they are not the only workers affected by the COVID-19 pandemic, the inadequate working conditions revealed during the first wave led to condemnation from professional bodies and the medical and nursing unions. Reactions also occurred concerning other groups of workers who have also been particularly affected by COVID-19 (members of local or national police forces, the armed forces, prison officers, etc.), although somewhat later.

During 2020, there have been various legal claims and continuous demands for recognition of COVID-19 as an Occupational Disease (OD) among HW. The first lawsuit was filed by the Fasamet medical union in the Region of Aragon\(^\text{8,9}\). As a result, the Aragonese Government and its Health Department was recently condemned by the High Court of Justice for insufficiently protecting the health of workers, which is inadmissible under Spanish law\(^\text{10}\). The demand for recognition of COVID-19 and its consequences as an OD has been led by the Spanish General
Council of Official Medical Associations\textsuperscript{4}, with unions such as those representing the armed forces supporting the campaign for their own members.

2. Changes in recognition in 2020. The consideration of COVID-19 since the outbreak of the pandemic can be broken down into different periods:

March 2020: Sick leave caused by COVID-19 was considered to be a common disease as defined in Royal Decree-Law 6/2020, of 10 March\textsuperscript{42}. However, this R.D. states that: “exceptionally, sick leave due to SARS-CoV-2 infection will be recognized as a Work Accident (WA)” but exclusively in relation to the economic benefits of temporary incapacity. This consideration also extends to preventive quarantine due to close contact with an infected person. Recognition as a WA means providing immediate and more generous benefits and protection to the worker than in the case of common illness but they are far less than for OD. Moreover, restricting recognition to economic benefits during temporary incapacity excludes other possible consequences such as those related to the employer’s responsibility regarding ODs and accidents at work.

April 2020: Royal Decree Law 13/2020, of 8 April 2020\textsuperscript{43}, modifies Royal Decree-Law 6/2020, establishing that periods of quarantine, contagion or restriction of movement outside a municipality (workers prevented from going to a workplace located in another municipality) are exceptionally considered as WA. Beneficiaries: all workers, and especially health professionals and social HW (caregivers of the elderly, particularly those in nursing homes, etc.). Nevertheless, it was up to the worker to prove the causal relationship between infection and the job.

May 2020: Royal Decree-Law 19/2020, of 26 May\textsuperscript{44} extended the recognition of WA in health professionals and social HW to the whole range of compensations (sanitary, economic, etc.) recognized by Spanish legislation. Moreover, HW would not need to prove a direct causal relationship between COVID-19 and their work. However, this provision was criticized for two reasons. Firstly, it left out other professionals at direct risk of contagion (for example, members of the armed/security forces or prison officers) and health and social care personnel who do not provide services in hospital, residential or social centers (for example, laboratory technicians, dentists or providers of home care services). Secondly, it restricted this enhanced protection to contagion occurring up to one month after the end of the state of alert and to deaths occurring within five years of that date as a result of such contagion.

Summer 2020:

i) The duration of this protection was extended by Royal Decree Law 27/2020, of 4 August\textsuperscript{45}, to all infections occurring from 1 August until the health authorities lift all preventive measures adopted to deal with the COVID-19 health crisis.
ii) The Spanish Parliament refused to urge the National Government to introduce measures to ensure that COVID-19 and all its consequences are recognized as an OD "for all purposes". The beneficiaries would be professionals in the National Health System who require leave from work, as well as members of the army and security forces, etc. COVID-19 has not therefore not been recognized as an OD yet, although this may change in early 2021.15.

3. Impacts of recognition as OD versus WA and Common Illness.
Workers' benefits are substantially different if their condition is recognized as a common disease (common illnesses and non-occupational accidents) or a work-related health problem (WA or OD)16. The economic compensation for workers during sick leave is greater for a work-related problem (whether an OD or WA). Furthermore, there are major benefits regarding both temporary and permanent incapacity. However, for employers the recognition of a work-related problem implies financial costs and may mean that inadequate preventive measures were taken, which can have serious consequences in terms of penalties and further payments. For workers, having their pathology classified as an OD, rather than a WA, has a number of advantages: 1) the worker has the right to be transferred to another job in the same company on the same salary. This does not apply when a WRA is recognized, and the worker may be obliged to register for permanent incapacity (receiving 55% of his/her Social Security contribution); 2) When an OD is suspected, the worker can enter an “OD Observation Period” (6 months cover, which can be extended for another 6); 3) Benefits for sequelae, permanent incapacity or death are payable at any moment, even after death. They do not expire, whereas for WA they are statute barred after 5 years16.

4. Recognition of COVID-19 as an OD according to Spanish law.
Royal Decree 1299/2006, of 10 November17, approves the list of ODs in Spain and COVID-19 caused by the SARS-CoV-2 virus meets the OD criteria for various types of worker, including HW. RD 1299/2006 came into force in January 2007 and defines ODs caused by exposure to biological agents as “infectious diseases caused at work in persons dedicated to prevention, medical care and activities in which a risk of infection has been demonstrated”, specifying that this applies to certain activities or jobs: healthcare personnel; healthcare and auxiliary staff in closed institutions; laboratory staff; non-healthcare workers in care facilities and those caring for the sick in outpatient and closed institutions or at home; research or clinical laboratory workers; work involving the collection, handling or use of human blood or blood products; dentists; aid personnel; prison workers; law enforcement personnel17. However, it establishes that the list is neither exhaustive nor closed, so it can be extended to other jobs, according to a Supreme Court Ruling18. For ODs caused by exposure to biological agents, RD 664/1997, of 12 May19, is also applicable. It specifies which infectious diseases are considered occupational for the purposes of the protective action of the Spanish Social Security System, expressly including those caused by viruses of the Coronaviridae family, such as SARS-CoV-2 (Annex II, RD 664/1997). Moreover, Spain has already transposed Commission Directive (EU) 2020/739, of 3 June 202020, which expressly includes

COVID-19 in health professionals and other workers (health, social and healthcare, prison officials, members of the Army or the security forces, etc.) clearly, therefore, meets the criteria for recognition as an OD for all purposes.

5. Current national discussion on this issue and results. We have yet to see structured discussion on this issue and there has been no real debate in society. EU guidelines and the recommendations of competent international bodies support a recognition which has not been reflected in Royal Decrees enacted by the Spanish Government in 2020, and which is inconsistent with pre-existing and consolidated Spanish regulations on HWs.

Surprisingly, on 27 December 2020, in their last meeting of the year, the Health Commission of the Spanish National Parliament unanimously agreed to ask the Government for this recognition (although exclusively referring to HW). This new initiative could be more successful, as it is supported by a cross-party group in Parliament (this has not happened before). Recognition of COVID-19 as an OD will be welcomed by health professionals, physicians and the professional bodies and unions that are campaigning for it. However, it should be extended to all workers at risk, not only HWs and without restrictions on the benefits that Spanish Law already establishes for ODs.
References and supporting data webpages

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https://www.boe.es/eli/es/rdlg/2015/10/30/8/con


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20. Directiva (UE) 2020/739 de la Comisión de 3 de junio de 2020 por la que se modifica el anexo III de la Directiva 2000/54/CE del Parlamento Europeo y del Consejo en lo que respecta a la inclusión del SARS-CoV-2 en la lista de agentes biológicos que son patógenos humanos conocidos, así como la Directiva (UE) 2019/1833 de la Comisión. Diario Oficial de la Unión Europea, de 4 de junio de 2020, L 175/11-14.

Covid-19 as occupational disease in the Netherlands

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Summary

Aim – to make an inventory of the way in which is dealt with Covid-19 cases of occupational origin in the Netherlands, as well as the discussion on the issue and the impact of the current policy with respect to occupational Covid-19 cases.

Methods – an exploratory search was conducted in the national scientific literature and public media in the Netherlands. Furthermore network information of key opinion leaders was used to draw up a picture of the discussion on the issue and the impact of the current policy with respect to occupational Covid-19 cases.

Results – Figures of occupational Covid-19 reported to the Netherlands Center for Occupational Diseases (NCvB) are displayed. The National Institute for Public Health and the Environment (RIVM), which reports the official figures on Covid-19 infections, does not report information about occupational Covid-19 cases, but only on the numbers of positive tests, hospitalizations and deaths. Although there are some initiatives from interest groups in health care and a modest number of pleadings for recognition of Covid-19 as an occupational disease with accompanying compensation in the professional literature and the public media, there is no extensive discussion on the issue of Covid-19 as occupational disease. Other issues, like the restriction regulations of the government and economic compensation arrangements, face masks, testing and vaccination, are more dominant in the public debate.

Conclusion – Covid-19 is not officially recognized as occupational disease in the Netherlands. The reason for this is the lack of a general compensation scheme for occupational diseases in the Netherlands. Compensation can be enforced by liability legislation, but in most cases this is a lengthy and complicated procedure. The debate on Covid-19 as occupational disease is still limited, but can grow into a big social and political issue when the extent of the damage becomes apparent.
Introduction

Covid-19 in the Netherlands is monitored by the National Institute for Public Health and the Environment (RIVM) in collaboration with the Municipal Public Health Services (GGDs). Comparable to other European countries there has been a first wave of Covid-19 in March-April 2020 and the Netherlands is now facing a second wave which started in September 2020. The second wave consists of two spikes in October and December 2020. In January 2021 vaccination of specific groups of health care workers and vulnerable groups has started. The total number of deaths due to Corona since the start of the pandemic in the Netherlands is 13,733 (27-1-2021).  

Covid-19 can be notified as an occupational disease to the Netherlands Center for Occupational Diseases (NCvB). The NCvB collects information on occupational diseases under the assignment of the Ministry of Social Affairs and Employment (SZW). Notifications to the NCvB are anonymous with respect to identity data of employer and employee and the data are merely used as input for government policy on prevention of occupational disease and provision of information on the issue to occupational health and safety professionals, unions and employers’ organizations, government institutions and policy makers.

Unlike the most European countries there is no general compensation scheme for occupational diseases in the Netherlands. There are, however, various categorical schemes in which compensation is arranged for specific diseases, such as asbestos diseases and chronic toxic encephalopathy. There are also schemes in some business sectors that entitle the holder to compensation for an occupational disease, such as for PTSD at the Police and Ministry of Defense and for diseases as a result of hexavalent Chromium exposure at the Ministry of Defense. If a disease is not covered by any of the categorical schemes or if the categorical scheme offers insufficient compensation, one must rely on liability legislation, which means that the victim should hold the employer liable for the damage suffered as a result of the work, which often leads to very lengthy proceedings of several years.

This study aims to make an inventory of the way in which is dealt with Covid-19 cases of occupational origin in the Netherlands, as well as the discussion on the issue and the impact of the current policy with respect to occupational Covid-19 cases. The main questions formulated by ETUI for this study are:

– Are there any cases in the Netherlands where Covid-19 is recognized as an occupational disease?
  • If yes, in which sector, activity, geographical area, company, etc.?
  • If yes, what impacts the recognition has on the employee, on the employer, and on the insurer?
  • If not, what measures are applied to the situation when an employee is infected at work by the virus and develops the Covid-19 disease?
– What is the current national discussion on this issue (e.g. trade union demands, employers’ and other stakeholders position, structured or non-structured discussion)?
Methods

An exploratory search in national literature and public media has been conducted. Foremost we used the publications on Covid-19 as occupational disease from the NCvB, the Netherlands Society of Occupational Medicine (NVAB), which is the association of occupational physicians in the Netherlands, and the RIVM.

Furthermore information has been retrieved from the website of the Ministry of Social Affairs and Employment, employers organizations and unions as well as interest groups. In collaboration with various professional organizations information on Covid-19 and work is distributed by the newsletter Arbo-inf@ct.

The selection and presentation of the abundant material is the responsibility of the author, who is acquainted with and participating in the national discussion on occupational diseases for more than 20 years. Besides, several key opinion leaders in the field of occupational health and safety and infectious diseases have been consulted to draw up a picture of the discussion on the issue and the impact of the current policy with respect to occupational Covid-19 cases.

Results

Since the first of April a special code was introduced by the NCvB to notify Covid-19 cases as an occupational disease. Tamminga et. al reflected on all reported cases till the end of October 2020. In the period from April to October 146 occupational physicians reported 1088 cases of occupational Covid-19, which was 47% of the total number of notifications of occupational diseases to the NCvB in that period. Most notifications are from the health care sector, mainly from the nursing and care homes (71% of the total number of notifications) and from the hospitals (21% of the total number of notifications). Mid December this figure had increased to 1424 cases. A majority of the cases (65%) was due to unprotected contact with an infectious patient or colleague. The RIVM reported a total number of 41,274 cases with a positive PCR test in the same period (April-October) in the health care sector, enforcement and contact professions without information about work relatedness of the cases.

The NCvB indicates that the underreporting of cases is significant, in the health care sector as well in other sectors in which many occupational cases of Covid-19 might be expected, like the catering sector and contact professions.

Although regulations and policy with respect to compensation of occupational diseases is underdeveloped on the national level and very complicated in practice because of the various categorical private and public arrangements in the field, there is a quite developed preventive legislation regarding health and safety at work. In the Netherlands every company is obliged to make an inventory of the health and safety risks at work and to draft a prevention plan (Risk Inventory and Evaluation: RI&E). In the meantime the corona virus must be explicitly mentioned as a risk in the RI&E and measures must be taken to prevent contamination and spread. Attention is also asked for working conditions at home, like ergonomic
and psychosocial factors, since a significant part of the working force is working at home since the start of the pandemic. In practice, several evaluations demonstrate that the implementation of the regulations on health and safety in companies leaves much to be desired, which also applies for the Covid-19 paragraph.

Frankenmolen et al. addressed the problem of a missing scheme for compensation of Covid-19 as occupational disease. Especially in cases with a serious course with complications leading to more or less permanent work incapacity, as well as in cases of “long Covid” in which symptoms of low energy and shortness of breath continue to exist, the lack of compensation arrangements might lead to a significant loss of income. This also applies to relatives of Covid-19 victims who died as a result of the infection. Under the current regime for occupational diseases based on liability claims, it will be complicated to prove one’s case in court and mindful of the experiences with other cases of occupational diseases the settlement of lawsuits can take several years. Therefore, the authors plead for a compensation fund with accessible and fast handling of claims.

The missing scheme for compensation was also recognized by the community of health professionals itself. A group of committed health professionals established the foundation “Stichting Zorg na Werk in Coronazorg (ZWiC)” (Foundation Care after Work in Coronacare). The foundation is financed by private donations and aims to assist healthcare workers and their family members and mitigate the financial consequences of an intensive care program or unexpected death.

If the damage due to Covid-19 infection is considered from the perspective of liability a distinction has to be made between liability of the state and liability of private parties. Legally this perspective is very relevant for the Dutch situation because of the government choice not to arrange compensation of occupational diseases by a national policy but via a case by case approach under the aegis of liability legislation.

The state can be held liable for the lack of information and even withholding information at the start of the pandemic. Furthermore, the state might be liable for the fact that stocks of protective equipment turned out to be too limited or the distribution of stocks were debatable, with sufficient stocks for intensive care units and significant shortage in the nursing and care homes and home care, being lowest in the hierarchy in health care. Precisely in that sector the numbers if occupational Covid-19 cases are the highest.

The lack of protective means is also relevant with respect to employer’s liability, in which the general shortage of protective equipment is probably not a valid argument for avoiding liability. For health care workers high requirements should be set for protection because of the high probability of contact with Covid-19 patients. Moreover, employers have special responsibilities towards vulnerable employees with increased risk of contracting Covid-19 or an increased risk of a severe course of the disease. This obligation has been violated on a relatively large scale by employers who forced their employees to come to work, in the health care sector as well in other sectors. A low point was the meat industry in which high numbers of Covid-19 infections occurred due to insufficient precautionary
measures at workplaces and the (sometimes) forced employment of foreign employees, in addition to bad housing conditions (often also arranged by employers or their contracting party) with a high risk of contamination.

Besides the discussion of the Covid-19 infection itself as an occupational disease, many additional topics kept the public debate busy. Working at home can cause ergonomic and psychosocial problems, insufficient or poor ventilation in schools and offices might increase the risk of contamination, more frequent handwashing especially in health care workers might increase allergic and irritant induced hand eczema and protective equipment such as face masks also can provoke dermatitis.

As already said the Dutch government did not introduce specific measures to compensate victims of occupational Covid-19 financially. However, just as in many other countries the government has provided extensive economic support measures for the indirect effects of Covid-19, such as the lockdown and the closing of sectors like catering and small retail business. But also large companies that encountered great losses due to the restrictive measures were compensated.

Interest parties like trade unions for nurses advocate, beside the request for provision of better protective equipment, recognition of Covid-19 as an occupational disease. In September 2020 one of the unions for nurses referred to 547 cases hospitalized and 13 deaths of health care workers in the age group 40-69 due to Covid-19. Till now the government did not respond to this demand and there is still no policy framework to implement recognition and accompanying compensation regulation. With respect to vaccination, lobbying of the health care sector was more successful and resulted in a change of the original vaccination strategy of the Dutch government. The original policy was to start vaccination in the most vulnerable groups, but lobbying of the sector lead to a change in policy in which some groups from the health care sector were vaccinated with priority.

Conclusions

As a result of the way in which is dealt with occupational diseases in the Netherlands there are no officially recognized cases of Covid-19 as occupational disease and there is no general compensation policy for occupational diseases at the very moment. However, occupational physicians have notified more than 1400 cases of Covid-19 to the NCvB as occupational disease in 2020 till Mid December, of which 90% comes from the healthcare sector.

Officially preventive measures and the use of protective equipment are laid down in legislation, but in practice these measures and especially at the first months of the pandemic adequate use of protective devices left a lot to be desired.

Interest groups in the health care sector have taken initiatives to recognize Covid-19 as occupational disease and to compensate victims of Covid-19. On governmental level there have been no initiatives to establish arrangements for recognizing Covid-19 as an occupational disease and accompanying regulations for compensation. The debate on Covid-19 as occupational disease is still limited,
but can grow into a big social and political issue when the extent of the damage becomes apparent.

**References**

The Current State of Play in the Recognition of the “Covid-19 as occupational disease”

ROMÂNIA

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Romania welcomes the E.T.U.I. initiative for launching the debate on "COVID-19 as an occupational disease". To summarize the evolution of “COVID-19 and world of work” approaches we used the medical, scientific, statistical, legislative sources, provided by the responsible authorities, both pre-existing (e.g. Institute and directorates of public health, hospitals for infectious or chronic diseases, ministries) and those strictly organized for the management of the pandemic (e.g. The National Committee for Emergency Situations, the special telecommunications service, the communication and alert systems, ambulance providers system, the dedicated institutional commissions, the I.T. platforms) to which are added the international ones: W.H.O. and the occupational health networks, the European agencies for safety and health at work, the European Centre for Diseases Prevention and Control, the universities and scientific researches.

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

COVID-19 is considered to be either of occupational etiology or a case of community origin or a COVID-19 healthcare associate case depending on:

1. the number of days prior to the date of onset or confirmation by the laboratory testing and after date of hospitalization in a health unit (hospital, dialysis center)/ residential center for extended stay;
2. the findings of the epidemiological investigation concerning the community origin or I.A.H.C.
3. the occupational medicine research results based on a compulsory framework; Following these researches there are few cases that can fulfil the requirements for recognition but the legislative framework is still under debate with the main authorities.

II. If yes, in which sector, activity, geographical area, company, etc.? Please describe the case(s) in detail, also including any limitations e.g., Covid-19 recognised as an accident not a disease

These COVID-19 cases are provided by the health authorities (occupational medicine specialists) from three counties that have fully completed the declaration procedure. This procedure bridged the gap between occupational exposure and
the disease, by excluding simultaneously the COVID-19 as community infection or a case associated with healthcare.

Most cases are doctors and nurses working in hospitals dedicated only to the diagnostic and treatment of the patients infected with COVSARS2. The classification of the sources of the virus among medical staff recognizes the same categories as the outline above, but must be based on an individual assessment of each case-exposure within the medical care provided in the health unit, respectively in the community.

It should be mentioned that the occupational medicine doctor is not involved in COVID-19 diagnostic and therapy, although all doctors and students can get involved in public health interventions.

Under the advices of the board experts from infectious diseases, epidemiology, emergency medicine, anesthesia and resuscitation, occupational medicine, safety consultants and the legislative boards of the ministries (health, internal affairs, labor and justice) these cases are waiting the fulfillment of the statutory requirements of the legislative framework for recognition.

The first requirement is:

*Creating a matching definition of the COVID-19 (infection with SARS-CoV-2 has been confirmed by laboratory testing irrespective of severity of clinical signs or symptoms) with the occupational disease one, while taking also into account the Classification of International Diseases 11th edition (ICD-11 with the update (09/2020)) including/excluding pneumonia, the associated multi-system-inflammatory syndrome or post COVID-19 conditions.*

The occupational diseases (those diseases that occur as a result of the work, a trade or profession, caused by harmful physical, chemical, psychological or biological factors specific for the workplaces, as well as by the overload of body organs or systems of the body during the work) are defined by occupational health and safety legislation and scientific treaties on occupational diseases. They grouped into 15 categories including “certain infectious and parasitic diseases”.

The COVID-19 disease is missing from the list of occupational infectious diseases currently agreed by law which is:

| Infectious hepatitis caused by Amoeba, Brucella, Rickettsii (Q fever), Hepatitis viruses and others |
| Tuberculosis - Mycobacterium tuberculosis (human and animal) |
| Hepatitis A, B, C, E - Hepatitis A, B, C, E virus |
| Leptospirosis - Leptospira |
| Brucellosis - Brucella |
| Tetanus - Clostridium tetani |
| Infectious and parasitic diseases, including tropical, for which the risk of infection has been assessed - biological agents according to Directive 2000/54/EC (including Coronaviruses group 2) |
The occupational character of the diseases is a result of a medical research made by the occupational medicine doctor from the counties’ Directorate(s) of Public Health, according to a regulated procedure. The research procedure includes the documentary, medical, therapeutic and legislative phases. These are compulsory in the process of obtaining funding for patients from the insurer (national pension subsequent public fund).

III. If yes, what impacts the recognition has on the employee, on the employer, and on the insurer (e.g., compensation coverage)?

By locking down the economic agents considered providers of cases (economic agents in high-risk industries, tourism, public catering and education) and schools, while simultaneously strengthening the hospitals specially designed to treat COVID-19 patients, the workplace contamination risk decreased. For employers, the economic and financial impact was important, but it was taken over by the State through fiscal and administrative measures, such as technical unemployment, remote work, work at home or teleworking. Consequently, the risk of community transmission and that specific to the health sector became priorities as we can see in “European Centre of Prevention and Control of Diseases’ fast risk assessment”.

All the decisions of the authorities influenced directly or indirectly the life and health of the workers. To ensure the compliance of every citizen and worker to at least two safety measures, e.g. social distance or wearing the mask, efforts were focused on all directions, institutional, community, public-private, including workplaces.

From the beginning, the occupational medicine experts discussed the issues identified (risk category of SARS-CoV2, expanding the list of occupational diseases, the role of epidemiological investigation as a tool, correlating the definition of the case with preventive measures, clinical frames) and used the time period of 2 years offered by the insurer to complete the regulations for recognition. The recognition of the Covid-19 cases investigated allowed the insurer to establish exactly the compensation coverage and also finance prevention programs, in addition to the ongoing community ones.

Finding the way to provide support for the surveillance of post condition phase of the disease and its potential impact on work capacity is another debate subject of the stakeholders.

IV. If not, what measures are applied to the situation when an employee is infected at work by the virus and develops the Covid-19 disease?

The personal protective equipment has been in constant attention and adaptation; improving the quality of protection of the masks, overalls, gloves, protective screens shoes. The intense debates focused on the choice of certified respirators (to reduce the airborne contaminants exposure, like FFP2, FFP3) or surgical mask (physical barrier to protect from hazards such as splashes of large droplets of body
fluids or blood) have turned into a business-case, reflected in choosing respirators for risky sectors and surgical masks for the population, especially in crowds, in social institutions.

Each stage was regulated by the authorities that assumed the coordination of the national interventions plans. Logistics was provided by a call center. I.T. platforms provided information, epidemiological surveys, community and workplace contacts. The financial measures looked further for the acquisition of medicine and protection, researches and innovations for transporting patients or healthcare workers directly involved in patient care. Meanwhile, the legislative instrument was extremely used and adapted for each course: the case definition, the measures to be implemented, screening, prophylactic or treatment protocols.

At the same time with 14 days of quarantine for treatment of the infected employee, the employers have to look into the guidelines issued for hygiene at work like those used for devices with UV radiation or for disinfectants and the related procedure, for the arrangement of medical offices, in particular those of occupational medicine.

The regular surveillance of workers’ health was allowed in multiple choices, e.g. with strengthening protection in the offices, through telemedicine for certain situations, adaptation of the periodicity, focusing on co-morbidities.

V. What is the current national discussion on this issue (e.g., trade union demands, employers’ and other stakeholders’ position, structured or non-structured discussion)?

Like other issues e.g. “the stress of the healthcare workers during pandemic”, the “COVID-19 as occupational disease” was the subject of webinars with stakeholders (E.A.S.H.W., W.H.O. focal points and networks in S.E.E. countries, trade unions) and the decision makers from the Ministries of Health and Labor.

From our perspective, we are gradually approaching its full compliance. Thus, for COVID-19 we have established:

* a confirmed case definition – the patient with the laboratory confirmation of SARS-CoV-2 infection, regardless of clinical signs and symptoms. We recognize here the standby position of the insurer for the O.D. extending list and coding, as well as the role of the occupational medicine doctor from the O.M. clinics who establish the occupational/professional diagnosis

* a risk assessment (made fast for each job by employer through specialists) and classified as small, medium, high; here we take into account the main economic sectors, as energy, transportation, food delivery, health sector; however, the categories of risks (occupational, epidemiological, biological, infection, contamination) builded like tools to be used are partially overlap.

We also included COVSARS2 in the “Risk Group 3” of biological agents that can cause serious illness in humans and pose a serious danger to workers; it may be a
risk of spreading in the community, but there is a generally effective prophylaxis or treatment (supplementing the European Directive 2000/54 by 2019/1833 and finally by 739/2020)

As, from 27th January 2021, at the proposal of the Ministry of Health following the scientific debates and the negotiating with active unions, the list of infectious diseases includes 9 caused by bacteria, 11 by viruses, 4 parasitic, 4 fungal as revealed in table:

<table>
<thead>
<tr>
<th>Viral Infectious Diseases</th>
<th>Viruses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis acute A</td>
<td>Virus hepatitis A from fecal</td>
</tr>
<tr>
<td>Hepatitis acute B</td>
<td>Virus hepatitis B from blood and other infected biological products</td>
</tr>
<tr>
<td>Hepatitis acute C</td>
<td>Virus hepatitis C from blood and other infected biological products</td>
</tr>
<tr>
<td>Hepatitis acute E</td>
<td>Virus hepatitis E from fecal</td>
</tr>
<tr>
<td>Infectious HIV/SIDA</td>
<td>Human immunodeficiency virus from infected blood and other infected biological products</td>
</tr>
<tr>
<td>Rabies</td>
<td>Virus rabies from the wild or domestic infected animals</td>
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<tr>
<td>Varicella</td>
<td>Virus varicella-zoster at human</td>
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<tr>
<td>Measles</td>
<td>Measles virus at human</td>
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<tr>
<td><strong>Infectious with SARS-CoV-2 (COVID-19)</strong></td>
<td>SARS-CoV-2</td>
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<td>Infectious with virus SARS</td>
<td>Virus SARS</td>
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<tr>
<td>The Middle East respiratory syndrome</td>
<td>Coronavirus associated to the Middle East respiratory syndrome</td>
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Short national study regarding current state of play in the recognition of Covid-19 as an occupational disease and/or national discussion on this issue – Hungary

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Legal framework of occupational disease

Aim – to make an inventory of the way in which is dealt with Covid-19 cases of occupational origin in the Netherlands, as well as the discussion on the issue and grow into a big social and political issue when the extent of the damage becomes apparent.

The occupational safety and health framework in Hungary have been harmonised to the European Union legislation before the Accession and new directives are being adopted in time. The coverage extends to employed persons only (private entrepreneurs are not subject of the Occupational Safety and Health Act1). Hungary swiftly ratified most ILO recommendations on occupational diseases. The evolution of compensation and reporting were parallel and only partially overlapping: there was a broader list of occupational diseases and a short list that entitled for compensation. This was ruled unconstitutional by the Constitutional Court2. Thus from 2007 on any occupational disease entitles for compensation.

The decree on the reporting and investigation of occupational diseases clearly sets the scope and the process.3 The list of occupational diseases to be reported slowly evolved and the current list includes titles that make any other case eligible. The list titles have ILO (R194) and EU list (2003/670/EC) equivalents and the coverage extends even to diseases due to psychosocial issues. The titles do not specify sectors or job titles but specific exposures (without determining quantitative criteria). This made the Hungarian system unique already during the first SARS epidemic: it could have been occupational disease had the pandemic reached the

1. 1993. évi XCIII. törvény a munkavédelemről. Available at: https://net.jogtar.hu/jogszabaly?docid=99300093.TV
2. 21/2006. (V. 31.) AB határozat. Available at: https://net.jogtar.hu/jogszabaly?docid=A06H0021.AB&txReferer=99700083.TV
3. 27/1996. (VIII. 28.) NM rendelet a foglalkozási betegségek és fokozott expozíciós esetek bejelentéséről és kivizsgálásáról. Available at: https://net.jogtar.hu/jogszabaly?docid=99600027.NM
country. This feature is still in force. From 2020 the list is maintained by the Ministry for Innovation and Technology, which is responsible for occupational safety and health. Hungary participates in the European Occupational Diseases Statistics programme run by Eurostat.

**Concept of occupational disease**

The Hungarian scientific concept of occupational diseases is based on individual, case-by-case proving of causal relationship. Therefore, the three requirements for an occupational disease are:

1. sound medical diagnosis;
2. exposure(s) that is(are) capable of causing the disease; and
3. temporal–spatial adequacy.

This latter takes into consideration the latency period and the dose-response relationship. Furthermore, common non-occupational causes need to be ruled out, like inherited diseases, lifestyle factors, community, household or hobby exposures.

**Registration process**

The process is set by legislation. Any medical doctor can report the suspicion of occupational origin of a disease. However, this is done mostly by the occupational medicine specialists working in occupational health services. General practitioners and clinicians report less as they are more focused on curative aspects and have less routine and/or training on the administrative process. Should there be no doctor willing to report the suspicion, the patient can directly apply to the labour inspection body, which will forward the case for reporting to the National Public Health Center, Department of Occupational Health (NNK-MFF). The reporting doctor has to fill a form and send it to the occupational safety and health inspection body of the regional government office according to the place of employment. These bodies have the authority to carry out inspections at place, make interviews (testimonies), collect documents. The aim of the inspection is to provide evidence of the exposures that can cause the disease at issue. The medical documents and the findings of the inspection are sent to NNK-MFF, where expert committees are discussing every case and make decisions on the basis of the submitted documents and the scientific evidence available. The committees consist of medical and hygiene specialists and can ask clarification, ranging from diagnosis to exposure assessment. The opinion can be positive (occupational disease is proven) or negative.

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negative (occupational disease is not proven). Negative opinion can result from unavailable data, missing scientific evidence for causal relationship, or severe biasing factor. When the committee members cannot agree the case is forwarded to second instance where a new committee comprising other senior specialists revises all the documentation. The decisions cannot provide graded opinion or assess the causality percentage of occupational factors. The decision is sent back to the inspection body, which forwards it to the social security paying-office (or to the health insurance body of the regional government office). The resolution on work-relatedness is issued on the basis of the expert opinion. The paying-office will automatically sum up the sick-leave payment to 100% and the patient will get right to free health care in relation to the disease (no co-payment). Any further compensation must be applied for, including the payback of previous co-payment costs related to the disease. The resolution can be challenged at court. Furthermore, the health insurer can demand from the employer all the health care costs due to the occupational disease.

**Aims**
The Hungarian reporting system has three aims: prevention, compensation, policy input.

**Prevention**
By the inspection the unfavourable working conditions can be identified and rectified. This can prevent new cases.

**Compensation**
Workers have the right to get compensation for the absence from work and ill health that is beyond their control.

**Policy input**
National level data collection can provide input for policy making, targeting prevention measures, launching campaigns.

Based on recent years experience, the Hungarian reporting system cannot fully realise any of its aim." This is due to counter-interest of involved parties. In the current occupational safety and health system the inspection related sanctions are the only measures that can motivate employers in investing in the safety and health of workplaces. The direct financial dependency of occupational health services to the employers can easily corrupt their reporting function. Employers are against inspections that may result in fines. Employees are afraid of losing their jobs either because of the employer’s revenge or by proving unfit due to the disease.

**Status of SARS-CoV-2 infection**

SARS-CoV-2 infection can be eligible for occupational disease. Due to the high number of cases and the risk of infection currently the inspection is done by asking the employer and the occupational health service to fill in a questionnaire. The expert committee is assessing case-by-case or by cluster of similar cases. There are not written rules for assessing the occupational origin. The below criteria are only guidelines that govern the decision making of the committee.

The diagnostic criteria for occupational disease is

- positive PCR or antigen test (with/out symptoms); or
- positive serological test plus symptoms

The above criteria mean that asymptomatic carriers can qualify too. This is due that the positive PCR or antibody test result means obligatory absence from work, regardless of symptoms.

Close contact (as in the WHO definition⁹) with SARS-CoV-2 positive index person in the incubation period qualifies for exposure. The person can be a patient/client/customer/co-worker. When no such person but a family contact is proven, the case is rejected. According to the legislation occupational disease applies to only employees and there is no restriction regarding sector or job title. As personal protective equipment cannot provide 100% protection the use of respiratory protection does not preclude registration. Compensation is available when the administrative process is completed.

**Sectorial features**

During the spring wave the infection rate of health and social care workers was higher.¹⁰ The autumn-winter wave is broader and the proportion of these workers is lower. However, this still means hundreds of reported cases. Reporting of other workers was scarce up to the completion of the manuscript.

By 16/Dec/2020 the webpage of the Hungarian Medical Chamber listed 36 healthcare workers (ambulance, nurses, specialists and general practitioners) who died due to COVID-19.¹¹ This list is based on information gathered from various sources. They may not have been reported and the occupational origin may not have been officially proven.

By mid-December three rounds of voluntary antigen testing were performed among kindergarten and school workers, healthcare workers and regional government officers. Overall 430,000 tests were made. The average positivity rate

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¹¹. MOK (2020). *A COVID egészségügyi áldozatai.* Available at: https://mok.hu/koronavirus/a_covid_egyeszsegugyi_aldozatai
was under 2%. Detailed data is available for the education and the health and social sectors. The participation rate was considered low (70%). Test positivity was 2.44% for the participants, which is translated as 1.64% positivity in the entire population concerned. Positive test results among participating workers ranged 1.8-2.6% in education, 1.96% in health care and 3.73% in social care institutions.

At the end of November the Ministry of Human Capacities (EMMI), which is responsible for health, sent a circular to every health care establishment on the proper reporting of SARS-CoV-2 infection as occupational disease.

Current national discussion on the issue

Trade unions demand more preventive measures and better staffing in health care. Many hospitals do not follow the minister’s request to provide full payment for quarantined health care workers: the enforcement thereof and more testing among health care workers is demanded. Trade unions in the education sector claim that many teachers got infected at work, therefore demand a complete shift to on-line teaching and launched a campaign for 100% sick-leave payment. Another trade union grouping demands more protection, IT infrastructure development enabling home-office and 100% sick-leave payment for public administration workers.

The disposition of reporting the suspicion of occupational origin varies hugely. Currently the occupational health services and the general practitioners have other urgent tasks and clinicians, who have never been in the forefront of reporting, are overwhelmed. The national investigation and expert opinion system is not prepared to such high number of reports and substantial delays are expected in the assessment process. The generous (open-list) and case-by-case approach of the Hungarian system can render giving expert opinion very difficult when the infection is widespread in the community and thus, on one hand, any co-worker and client, or on the other hand any relative and friend may be the source of infection.

17. Pedagógusok Demokratikus Szakszervezete (2020). nedolgozzingyen.hu webpage. Available at: https://nedolgozzingyen.hu/
All in all, the Hungarian occupational diseases reporting system can address the coronavirus pandemic. The process could be swifter, had there been no substantial shortcomings within the Hungarian occupational safety and health system:

- Counter-interest of stakeholders
- Lack of incentives
- Poor occupational safety and health literacy and culture
- Decades of cutting down in the public health and inspections administration
COVID-19 as an occupational disease in Poland

dr n. med. Marcin Rybacki

It's very difficult to answer the question if there are any cases of COVID-19 recognized as occupational diseases in Poland, due to the established procedures in our country and the time needed to gather such information. First of all, it's necessary to describe the system for recognizing occupational diseases in Poland.

From a legal point of view, the main stakeholders for health and safety at work are:

- Ministry of Labour and Social Affairs (Ministerstwo Pracy i Polityki Społecznej) - responsible for issues related to occupational safety and hygiene (including the transposition of the majority of the EU OSH directives). The Ministry supervises the activities of the Work Safety and Hygiene Service.
- The Ministry of Health (Ministerstwo Zdrowia) - responsible for issues related to occupational health (medicine) and the monitoring of the occupational medicine service (OMS).
- The State Labour Inspectorate plays a significant surveillance role by checking if the employers fulfil their OSH obligations. The Inspectorate also conducts awareness-raising campaigns on OSH.


Proceedings regarding occupational diseases are divided into two stages:

- recognition of occupational diseases, which is a medical decision
- notification of occupational diseases, which is an administrative decision.

Thus, both notification and recognition of occupational diseases are regulated by the Labour Code Act and the relevant ordinance. Occupational disease is a medico-legal concept. It is defined as a pathology caused by harmful factors occurring in the work environment or by the way of performing a job, and included in the official list of occupational diseases. The Ordinance by the Council of Ministers of 30 June 2009 on occupational diseases contains the list of occupational diseases and specifies how to collect information about their incidence: “§ 9.1. District state sanitary inspector or provincial state sanitary inspector, within 14 days from the date on which the decision about diagnosing an occupational disease has become final, fills in an Occupational Disease Reporting Form and sends it to the Central Register of Occupational Diseases run within the Nofer Institute of Occupational Medicine in Lodz”.
Recognition of an occupational disease in an employee (or a former employee) can either occur during his employment or after its completion provided that relevant symptoms are documented, appear in the registry and concern the employment period in question. The employer and his/her physician are obliged to report every possible case of an occupational disease to the local sanitary inspectorate and to the district labour inspector. The suspected person is then referred to a respective unit (regional centre of occupational medicine) where an authorized physician (occupational medicine specialist) issues a medical certificate to say whether the examined subject suffers from an occupational disease. In case of an appeal, the certificate is reconsidered by scientific-research institutes operating in the field of occupational medicine. Institutes can be also asked for a consultation by regional centres, which is often the case in occupational allergy field, where specific provocation tests are needed or in occupational cancer.

The OD recognition process is carried out in dedicated occupational disease clinics located in the regional centres of occupational medicine. There are 20 such regional units in the country. Currently, there is only one institute of occupational medicine, which is supreme to the regional centres and used to appeal against the certificates issued in the centres. Every year approximately 6,000 possible OD cases are reported and immediately scrutinized.

In the case of infectious diseases, occupational diseases can also be recognized in independent infectious diseases wards and clinics, over which occupational medicine specialists have no control.

The result of above diagnostics is recognition of the suspected occupational disease or the lack of it. The statement as medical document can be seen only by a patient or medical service, so at this level the employer does not know the results. Subsequent proceedings are handled by the sanitary inspectorate. Based on the medical certificate and other supporting documentation, the local sanitary inspector then issues a conclusive statement whether the examined subject suffers from an occupational disease. Both the employer and the (former) employee may turn to the regional sanitary inspectorate and appeal against the statement. The decision may be also challenged against in the Administrative Court.

This complicated procedure takes time, so between the notification of the suspicion of an occupational disease to the official recognition of the occupational disease, it may take half to even one year.

It must be mentioned that in practice, suspicions of occupational diseases are not reported automatically, but only at the request of the person that got sick. Even if the suspicion is made by employer or a physician (according to the law) – it’s up to the employee whether he or she wants to undergo the investigation. Due to complicated procedures, many workers are not interested in having their disease recognized as occupational. Moreover, employees often fear that if they are diagnosed with an occupational disease, their employers will not want to continue to employ them. This also explains the phenomenon occurring in our country, that it’s the elderly and retired workers who most often apply for recognition of an occupational disease.
The list of occupational infectious diseases is open, so every infectious work-related disease can be recognized as occupational, including COVID-19.

The Supreme Medical Chamber appealed to the Ministry of Health to recognize COVID-19 as a separate occupational disease to ensure that it would always be considered an occupational disease among medical personnel. However, this proposal was rejected due to the fact that in Poland any infectious disease can be considered an occupational disease, regardless of the type of work performed. Therefore, it was decided not to include COVID-19 on the list of occupational diseases as a separate occupational disease, because then other infectious diseases, such as hepatitis, TBC, etc., should be listed.

The latest data show that until 1 December 2020 the coronavirus contributed to the death of 43 physicians, 32 nurses, 6 dentists, 3 pharmacists, 2 paramedics and 2 midwives. The reports show that from the beginning of the epidemic in Poland, the coronavirus infection was detected in 15,720 physicians, 1,253 laboratory diagnosticians, 40,669 nurses, 3,754 midwives, 2,487 paramedics, 1,407 dentists, 1,636 pharmacists and 20 medical assistants. We have no data how many of these cases have been reported as suspected occupational disease and how many of them have been recognized as occupational diseases.

The challenges faced by occupational medicine physicians include defining COVID-19 as an occupational disease. It is necessary to determine whether the virus infection itself (without any symptoms) can be considered a disease. If not, it is necessary to determine the type of symptoms and their intensity, and to establish how they should be documented.

The questions that concern our environment also concern the type of test used to confirm the infection. The PCR test is not open to discussion, but making the diagnosis based on antigen tests or on the presence of antibodies is not so obvious.

As mentioned above, the law does not attribute particular occupational diseases to the type of work performed. In the current epidemiological situation, however, we are considering recognizing COVID-19 as an occupational disease in specific work sectors, such as healthcare or education. In the case of other professions, during which the acquisition of infection is proven (e.g. from co-workers), we consider considering such an event as an accident at work. This approach may, however, be challenged by the courts during a trial initiated by employees.

If an occupational disease is diagnosed, the employee is entitled to a one-off compensation. Its amount is determined on the basis of the percentage of health impairment based on a decision issued by the Social Insurance Institution. However, this decision is independent of the physicians who give opinions on occupational diseases. An employee may be also entitled to a disability pension if his/her health condition becomes severely impaired. The amount of the benefit is always higher when the loss of health is caused by an occupational disease as compared to natural causes not related to work.
Finally, it is regrettable to say that Poland has not identified one single institution responsible for identifying and solving the above-mentioned problems and whose opinion will be treated as binding law. The Polish Society of Occupational Medicine may issue appropriate recommendations, but this does not mean that they will be applicable in all judicial units.
Current state of play in the recognition of COVID-19 as an occupational disease in Croatia

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Introduction

Occupational diseases are diseases directly induced by work and working conditions. In the Republic of Croatia, through procedure set out by law, occupational diseases are reported and recognized by Croatian Health Insurance Fund and registered and monitored in the Registry of Occupational Diseases kept by the Croatian Institute for Public Health – Department of Occupational Health. Diagnosis and recognition of occupational diseases is a complex and lengthy process that requires special knowledge of medicine and other areas related to health and safety at work. Diagnosis are under responsibility of occupational health specialists and is carried out according to modern occupational health criteria, which includes determining the clinical picture of the disease and the damage caused by the work process. The current health crisis caused by the pandemic of the new infectious disease COVID-19 points us to several challenges in the field of health and safety at work in the Republic of Croatia, including the administrative problem of reporting and recognising occupational diseases caused by COVID-19. At the beginning of April 2020, an amendment to the Regulation on Infectious Diseases completely removed all administrative barriers to the recognition of occupational diseases caused by COVID-19 infection. According to the provisions of the Compulsory Health Insurance Act in Croatia, occupational diseases are diseases caused by a longer direct impact of the work process and working conditions on certain jobs. Occupational diseases in Croatia are covered by mandatory health and mandatory pension insurance. Benefits are paid from mandatory health insurance in case of temporary incapacity for work, while benefits in case of disability and physical impairment are paid from pension insurance.

COVID-19 as occupational disease in Croatia

The list of occupational diseases, jobs in which these diseases occur and the conditions under which they are considered occupational diseases are determined by the Law on the List of Occupational Diseases (Official Gazette 162/98) and The Law on Amendments to Law on the List of Occupational Diseases (Official Gazette 107/07). Only those diseases on the official list are considered occupational
diseases and jobs in which occupational diseases occur are considered jobs in which workers are exposed to chemical, physical and biological hazards and stresses from the List of Occupational Diseases.

The Law on Amendments to the Law on the List of Occupational Diseases (Law) under item 45 contains: "Infectious or parasitic diseases caused by work in activities where an increased risk of infection has been proven", which is applicable to the reporting and recognition of COVID-19 as an occupational disease. Article 2. of this Law defines an occupational disease and the conditions under which these diseases are considered occupational diseases:

"(1) An occupational disease is a disease for which it is proven that it is a consequence of harmful effects in the work process and/or work environment, or a disease which is known to be a consequence of harmful effects related to work process and/or work environment, and the intensity of the harm and the duration of exposure to that harm is at a level known to cause damage to health.

(2) Occupational diseases referred to in paragraph 1 of this Article shall be proven by means of treatment programs (algorithms) accepted in occupational medicine, and the diagnostic procedure shall include: 1) work history and proving the connection between the disease and exposure at work; 2) clinical picture with the appearance of impaired function and/or morphology of organs or organ systems that are known to cause certain occupational hazards; 3) positive findings of diagnostic methods that can objectify this damage.

(3) The presence of harmfulness referred to in paragraph 1 of this Article shall be determined: 1) by hazard assessment or in another way that enables the presence of harmfulness to be determined with certainty, 2) by determining intensity, measuring, direct insight into working conditions or in another way enabling to determine with certainty the intensity of harmfulness) and the duration of exposure to that harmfulness."

The highest number of reports of occupational disease caused by COVID-19 infection are expected among health care workers but it is also possible in other professions that are necessary for the functioning of the state in a pandemic (for example, police officers, border guards, education, traders and other service industry working during pandemic).

A workers who is diagnosed with an infectious disease caused by COVID-19, and work at a workplace where they believe that there is an increased risk of COVID-19 infection, should contact the occupational health specialist (OHS) that is in charge of their workplace by phone or in person (if the worker is cured or COVID 19 negative). OHS will submit the necessary documentation and diagnostic procedure will be carried out in accordance with Article 2, Paragraph 2 of the Law.

1) The diagnostic procedure begins with an inspection of the medical documentation that proves that the worker suffers from an infectious disease caused by COVID-19.
Laboratory documentation in accordance with the taken biological material for detection of infection (nasal and pharyngeal swab, nasopharyngeal aspirate, bronchoalveolar lavage, sputum, serum) – PCR testing

Clinical documentation - findings of an infectologist and / or other medical findings as needed

2) The procedure continues by proving the connection between the disease and exposure in the workplace, which includes:

a) Taking a detailed work history directly or indirectly through an official job description (Form 2 IN) or an excerpt from a risk assessment document for the job in question, with:
   • A list attached by the employer with the employee’s duties performed and business trips abroad if there were any in the period of one month before the onset of symptoms, or a statement that the employee was exposed to COVID-19 at work for a period of one month before the onset of symptoms diseases
   • Data on the use of protective equipment during work in the period of one month before the onset of symptoms of the disease

b) Taking a detailed personal history and confirmation from the family physician about other diseases or insight into the personal health records if it is not possible to conduct a worker inspection

c) Taking an epidemiological history of COVID-19 family members and others contacts outside the workplace, information on non-working days and private trips in the period of one month before the onset of symptoms of the disease (in the form of a written statement workers if it is not possible to conduct an examination of workers)

After reviewing the above documentation, OHS will complete the procedure for diagnosing an occupational disease, i.e. give an opinion on the existence of an occupational disease.

Current situation in Croatia (December 2020)

Since we are still in reporting period for 2020, till this date there is only unofficial data. According to the Croatian Institute for Public Health – Department of Occupational Health in period from March till December 2020 they received 248 application for recognition of occupational disease due to COVID-19 disease. More than 60 applications were refused due to the incomplete documentation and sent back to the applicants. Near two thirds of applications - 163 (65,7%) was accepted as an occupational disease with this distribution:

• Health and social care: 137 (84,05%)
• Public administration and defence: 12 (7,36%)
• Manufacturing: 5 (3,67%)
• Education: 5 (3,67%)
• Financial and insurance activities: 3 (1,84%)
• Other public services: 1 (0,61%)
As it is seen, health and social care sector are predominately represented in COVID-19 caused occupational disease. Majority of these workers are doctors and nurses that were working with COVID-19 positive patients. Even if worker is without symptoms, but with positive PCR findings it is considered as an occupational disease.

Currently Croatian Society of Occupational Health and School of Medicine University of Zagreb are developing on-line diagnostic tool in the diagnosis of COVID-19 as an occupational disease among healthcare professionals. Working version (on Croatian language) is available at: https://forms.office.com/Pages/ResponsePage.aspx?id=Ym1J7H5ShkKXGk7dFFJ_xeAcA1fGZHVOrgPrkVZcruUMET1UMQ0ruQ1lMSlFIOUxRTUFUVEhQSTI2WC4u

Members of Croatian Society of Occupational Health also developed and published Guidance on the procedure for reporting occupational diseases caused by COVID-19 and Recommendations for employers during COVID-19 pandemic that are available on Croatian language on their web site (www.hdmr.hr).

During October 2020, the Croatian Institute of Public Health revised its recommendations on SARS-CoV-2 testing priorities, contact monitoring, the end of isolation and self-isolation process. The changes compared to earlier versions are as follows:

- The self-isolation of a person who was in close contact with a person infected with COVID-19 is shortened from 14 to 10 days. Exceptions are persons working in institutions for accommodation and stay for the elderly and seriously ill persons and persons with disabilities, in which the quarantine lasts 14 days.
- Criteria for termination of isolation were divided into four categories of patients: patients with mild or moderate clinical picture, patients with severe clinical picture, patients who were immunocompromised and asymptomatic patients with COVID-19

The clinical criterion for termination of isolation of a symptomatic patient is a minimum of three consecutive days without fever without the use of antipyretics and a significant improvement in other symptoms.

There are currently 28 test sites in Croatia performing RT-PCR analysis of collected samples of COVID-19. All processed samples are entered into a national platform at the Croatian Health Insurance Fund, and this information is available to all county public health institutes. A new method of testing using rapid antigen tests is being applied in several cities and counties. Rapid antigen tests are used to diagnose symptomatic individuals in the first five days of illness. If the rapid antigen test is negative within five days of the onset of symptoms, or more than five days have passed since the onset of symptoms, the patient should be tested by using the PCR method. Due to lower sensitivity, this new testing method is not used to exclude COVID-19 disease. A negative result of a rapid antigen test should be confirmed by PCR to rule out false-negative findings.
Workers insurance and rights after recognising COVID-19 as occupational disease

In the case of an occupation disease, workers are insured not only if they are employed or self-employed, but also if they are members of a special group of insured persons for whom insurance is provided. These are, for example, pupils and students during practical training, vocational practice, study tours, and members of voluntary fire departments during fire-fighting activities. No prior insurance is required to be eligible for benefits in the case of an accident at work or an occupation disease. This holds true for benefits when incapacitated for work, i.e. sickness, as well as when claiming invalidity pension, professional rehabilitation and survivor’s pension. The procedure for determining and recognizing an illness for an occupational disease is initiated by submitting a form "Application for an occupational disease" which is submitted to the regional office or regional office of the Croatian Health Insurance Institute competent according to the place of residence or stay of the insured person or of the employer. The application is submitted by the employer or a person who independently performs personal activity and the organizer of certain jobs and activities referred to in Article 16 of the currently valid Compulsory Health Insurance Act.

The application can be submitted “ex officio” or at the request of a sick worker, i.e. an insured person who is provided with rights in the event of an occupational disease pursuant to this Act. If the employer, i.e. the organizer of certain activities and jobs does not submit an application for an occupational disease, the application must be submitted by the selected doctor of general / family medicine at the request of the injured or ill insured person or at the proposal of the competent doctor of occupational medicine with whom the Croatian Health Insurance Institute has concluded a contract on the implementation of specific health care for workers, which is responsible for the implementation of specific health care for workers according to the seat of the employer, i.e. the organizer of certain activities and jobs.

An application for recognition of an occupational disease and determination of the right to compulsory health insurance due to an occupational disease may also be submitted by the ill insured person himself, or by a family member in the event of the death of the insured person.

The deadline for submitting an application for an occupational disease or application is 8 days from the day when the insured person received a document from a health institution or doctor's office in private practice included in the network of contracted occupational medicine entities, which diagnosed him with an occupational disease. An insured person for whom an application for an occupational disease has not been submitted to the Croatian Institute within three years from the expiry of the aforementioned period loses the right to initiate the procedure for determining and recognizing an occupational disease by the Croatian Health Insurance Institute.
Under health insurance, workers may also claim the following due to an occupational illness:

- Screenings and diagnostic procedures as part of specific healthcare at a specialist doctor chosen by the employer. If they are self-employed, they can choose their own doctor;
- In the case of suspicion of an occupational disease, proceedings must be instituted at the competent local office of the Croatian Health Insurance Fund (HZZO). This is done by employer and chosen primary health care doctor;
- Sick leave is dealt with by your chosen primary healthcare doctor.
- Travel costs can be claimed by submitting an application to the competent local office of the HZZO.

Within the pension insurance system, workers may be entitled to invalidity pension, occupational rehabilitation and impairment benefit.

Impacts the recognition on the employee

- Based on a recognized occupational disease, employees are paid 100 percent of the base for incapacity for work for 18 months without interruption
- After the expiration of this period employees are entitled to a salary compensation in the amount of 50 percent of the last paid salary compensation in the name of that temporary incapacity, while there is a medical indication for temporary incapacity.
- Reimbursement of transport costs related to the health care, as well as reimbursement of funeral expenses.
- More favorable financial conditions in determining the amount of disability pension. The right for financial compensation for bodily injury.

Impacts the recognition on the employer

- Contribution for compulsory health insurance in case of injuries at work and occupational diseases at the rate of 0.5% on monthly profit.
- Referring workers to perform medical / medical examinations, previous and periodic and, if necessary, control and extraordinary medical examinations
- Contracting the performance (management) of occupational safety
- Preparation of additional risk assessment
- Development of training programs to work in a safe manner

The Croatian Health Insurance Institute is obliged to return the funds paid by the employer to the employer within 45 days from the day of receipt of the request for refund.
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COVID-19 as an occupational disease in the Czech Republic

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Introduction

The disease called COVID-19 is a communicable infectious disease caused by the coronavirus SARS-CoV-2, highly infectious agent transmitted from person to person. The COVID-19 pandemic is considered to be the most serious health threat since the global influenza epidemic (so-called Spanish influenza) in 1918–1920 caused by the H1N1 influenza A virus. On March 1, 2020, the first cases of COVID-19 in the Czech Republic were reported (1). In response to the unfavorable epidemiological situation, the government declared a so-called state of emergency in accordance with the constitutional law and adopted a number of measures, including restrictions on movement, closure of schools and restaurants, regulation of travel and entry of persons into the territory of the Czech Republic from abroad, possible postponement of occupational medical preventive examinations for the medical fitness assessment for work, the obligation to wear veils, the allocation of hospital beds, and others (2). While in the spring of 2020, due to restrictive anti-epidemic measures and their acceptance of population, the course of the epidemic in the Czech Republic was very favorable, since autumn 2020 there are significant daily increases in new cases of COVID-19, hospitalized patients, including severe cases in intensive care units, and people who have died of the infection. This change was caused by the release of restrictions in the summer and especially by the late reintroduction of restrictions in early autumn, influenced by pre-election political decisions, disrespect for expert recommendations and the rejection of restrictions by a certain part of the population. It should be added that government measures are still very inconsistent, permeated by numerous exceptions (industry versus services) and frequent illogical changes, which significantly contributed to the rejection of restrictions during the time of community spread of the infection, which leads to difficult or impossible capture contacts. While the industry has not been affected by all government restrictions, hotel and restaurant services have been affected very significantly and trade has been partially affected.
Recognition of occupational diseases

Czech legislation differentiates between occupational diseases and so-called “endangerments” by an occupational disease (3).

An occupational disease is defined as a disease caused by the noxious effects of chemical, physical, biological, and other factors, provided that the disease originated under conditions described in the List of Occupational Diseases.

An endangerment by an occupational disease is defined as a health impairment which occurs during the performance of a working activity as a result of a noxious effect of the conditions which are known to cause an occupational disease. While the health impairment does not meet the prerequisites for being recognized as an occupational disease, such a disease might ensue if the work under those conditions continues.

An occupational injury is health damage or death of an employee if it occurred independently of his will due to short-term, sudden and violent exposure to external influences in the performance of work tasks or in direct connection with him.

It is clear from the list of definitions that a disease referred to as COVID cannot be considered as an injury from a medical point of view and the term accident is not appropriate in this context.

Occupational diseases are assessed and recognized only by providers of occupational health services in the field of occupational medicine who have obtained a permit from the Ministry of Health to recognize occupational diseases in accordance with the law (https://www.mzcr.cz/seznam-poskytovatele- kterym-byl-udeleno-povoleni-uznavat-nemoci-z-povolani/). The process of assessment and recognition of an occupational disease always takes place at the locally competent provider recognizing the occupational disease and the principle of free choice of doctor does not apply here. In accordance with the Public Health Protection Act, the regional public health inspectorate verifies the conditions for the occurrence of an occupational disease for the purposes of assessing an occupational disease in the event of a reasonable suspicion of an occupational disease and at the request of a provider recognizing an occupational disease. The statement of the regional public health inspectorate to verify the conditions of the occurrence of the disease for the purposes of assessing the occupational disease is binding for the provider recognizing the occupational disease.

In the Czech Republic, there is compulsory statutory insurance for employers in the event of an occupational disease, endangerment of occupational diseases or an occupational injury. According to the Labor Code, an employee whose risk of infection can be proven in connection with the performance of work activity may assert the following claims against the employer:

- loss of earnings,
- pain and difficulty in social fulfillment,
- reasonable costs associated with the treatment,
— material damage,
— in the event of the death of an employee as a result of an occupational disease, the employer shall reimburse the costs of maintenance for the survivors, one-off compensation and compensation for material damage.

Occupational exposure to coronavirus SARS-CoV-2

The possibility of transmitting the pathogen (coronavirus) during the work is considered to be one of the most important, although valid data are still not available. It is difficult to obtain valid information about the transmission of an infectious agent in a specific environment (at work or out of work, during school lessons or out of school, in or outside a shop, in or out of transport). The probability of transmission of infectious agents is modified by its dose, climatic conditions, indoor stay, ventilation, introduction or release of restrictions, presence at work or outside, use of a means of transport and other factors that are difficult to predict. It is quite logical to expect that health and social workers are most at risk in this regard. By January 4, 2021 COVID-19 had been confirmed in more than 50,000 persons in healthcare, of whom 31 died in total, including 14 physicians and 8 nurses (6,500 sick patients, of which 1,350 doctors and 2,900 nurses). By January 7, 2021 there have been positive PCR tests in 598 physicians, 1651 nurses and 1217 other healthcare workers (together 3466 persons in healthcare).

Recognition of COVID-19 as an occupational disease

For the recognition of COVID-19 as an occupational disease according to current legislation, the following conditions must be met: clinically manifest disease confirmed by laboratory examination and hygienic investigation of work conditions described in the List of occupational diseases (Government Regulation No. 290/90 Coll., Chapter V, items 1 and 3). Verification of work conditions (hygienic criteria) is associated with so called risk of infection. In this context, the risk of infection means a higher probability of transmission of infectious agent (coronavirus) during the actual performance of work activities than during the usual performance of work and normal contact with other persons, even during the epidemic occurrence of the disease. Proof that the disease actually arose in direct connection with the performance of work (eg contact with a specific person) is not necessary (4).

The fulfillment of the conditions for the occurrence of an occupational COVID-19 is assumed in particular:
— for healthcare professionals,
— for workers in social services facilities,
— for students in connection with an ordered work duty to ensure the provision of health and social services,
— for teachers, especially when working with disadvantaged groups with a more difficult ability to comply with hygiene rules in general,
— for members of the police, army, fire brigade, where the transmission of infection in risky contact with a person during the performance of their work cannot be completely ruled out.

In contrast, in other occupations (administrative work, sales of goods, in manufacturing plants), where compliance with applicable anti-epidemic measures is not expected to be more likely to spread the infectious agent (coronavirus) than in the general population.

Therefore, if a person (health care provider or non-medical person, e.g. social worker, police officer, firefighter) with a suspected occupational disease COVID-19 became ill with a clinically manifest disease with a laboratory-confirmed diagnosis of COVID-19 and during the incubation period of this disease had close professional contact with a patient or other person with proven CoVID-19 positivity during the incubation period of that patient or other person or at the time of manifest manifestations of the disease, then the criteria for an occupational disease are met. Working with infectious material (for a laboratory worker, a hospital cleaner, etc.) is also considered as a risk of infection. If a person (both a healthcare professional and a non-healthcare professional) was tested positive for the virus (nasopharyngeal swab and / or serologically) but has not had clinically manifest COVID-19 (had no or even mild clinical signs, for example was only quarantined), then they are not currently met valid criteria and it is not an occupational disease.

The endangerment of occupational diseases means changes in the state of health which occurred during the performance of work due to the adverse effects of the conditions under which occupational diseases arise, but do not reach such a degree of damage to health as can be considered an occupational disease, and further performance of work under the same conditions would lead to the development of an occupational disease (Labor Code, paragraph 347). Recognition of so-called endangerment of occupational diseases in this disease according to applicable legislation is not possible.

By January 21, 2021 COVID-19 as an occupational disease had been confirmed in 153 persons (in 129 healthcare professionals, 22 professionals in social care, 2 in other occupations), but the number of applications for recognition of COVID-19 as an occupational disease is rising sharply to hundreds.

UEMS Section of Occupational Medicine is preparing now Statement on COVID-19 as occupational disease based on sufficient occupational exposure through taking the occupational history, results of epidemiological circumstances at the workplace and exposure. COVID-19 can be recognized as occupational disease in any sector at any workplace where work tasks are necessarily associated to close contacts with (potentially) COVID-19 patients and/or COVID positive contacts. COVID-19 should be recognized as occupational disease where there is increased risk for COVID-19 infection in working process but this risk should be taken into account individually case by case (higher epidemiological risk than in general population). Personal protective equipment does not exclude COVID 19 to be recognized as occupational disease (5).
References

5. UEMS-OCCUPATIONAL MEDICINE Statement on COVID-19 as occupational disease (Draft, January 8, 2021)
Are there any cases in your country where Covid-19 is recognized as an occupational disease?

Pedro Gustavo Reis, MD

In Portugal the Ministry of Health has recorded about 6660 cases of COVID-19 until the end of October. Of these, 3,149 cases have been notified as such, which are being evaluated by the organism in charge of its recognition.

These cases are being evaluated by the Department for Prevention and Repair of Occupational Diseases (DPRP), which is integrated in the National Institute of Social Security (INSS).

Of the 3,149 cases that have been notified until the end of October, 542 have already been recognised as an occupational disease (OD).

In Portugal, infectious diseases are, as a rule, considered as OD in health care worker (HCW) as long as they are due to their daily practice with exposure to patients with the same disease as the source of the one diagnosed in the HCW, whether the workplace be in Emergency Units, Medical or Surgical Departments, or cabinet rooms of different specialties, wherever health care professionals have contacts with patients that may eventually have an infectious disease, namely COVID-19.

The Portuguese system for the recognition of OD is based upon establishing the causal link between the exposition to the risk factor. Concerning COVID-19, the eventual exposure to a patient with the disease and the subsequent diagnosis of this disease in the HCW, is considered sufficient to establish such presumption.

As to COVID-19, there are situations that are easier to establish the causal link between the exposure to patients with COVID-19, as it is the case of HCW that work in Emergency Departments or dedicated infirmaries for COVID-19 patients, as well as those in laboratories where tests for SARS-CoV-2 are performed, namely, RT-PCRs. But even for HCW that work in departments where the exposure is not so evident, and the causal link may pose some reasonable doubt, the infectious diseases are usually recognised in HCW as an OD. This same criterion has been used in this pandemic situation.

The recognition of an OD in Portugal is similar to the French regulation, that is, there is a certified List, which is revised periodically. For the moment, and being a new disease, COVID-19 in not yet included in the National List of Occupational Diseases (NLOD).
Nevertheless, despite this NLOD, as the Portuguese system of recognition of OD is an open one, it is possible to proceed with such recognition, by the medical experts of the DPRDP, of diseases not yet included in the last version of the NLOD, if a clear causal link is established between the exposure to a risk factor.

Concerning COVID-19, an exposure by HCW to patients with the disease is considered as sufficient proof as a causal link to be recognised as an OD, in case the HCW becomes positive, even without symptoms.

The regular performance of tests of the HCW allows the surveillance and identification of those that get a positive test.

The inclusion of Coronavirus diseases, and particularly SARS-CoV-2 and COVID-19, are being considered for inclusion by the Committee that is presently reviewing the NLOD.

**If yes, in which sector, activity, geographical area, company, etc.?**

Please describe the case(s) in detail, also including any limitations e.g. Covid-19 recognised as an accident not a disease.

The sectors and activities that fulfil the criteria for recognition of COVID-19 as an OD in Portugal are the ones that were already mentioned, that is, HCW and environments where there is a possibility of getting in contact with someone carrying the virus.

Therefore, HCW are the ones in whom the causal link is easier to establish and to accept the relationship between the exposure to SARS-CoV-2 and COVID-19.

In some cases, it is not absolutely clear that the disease, even in an HCW, is due to an exposure that took place at the hospital, clinic or transport of a patient with COVID-19, or if the disease is due to a contact that took place in the community. In case of doubt, if there is a reasonable possibility that the contact may have taken place at the hospital, clinic, or the transport of patients with COVID-19, the notification is accepted and the disease is recognized as an OD.

On the other hand, if the HCW performs only administrative tasks, the disease is not recognised as an OD.

Besides HCW, COVID-19 may be recognised in security officers (Police, Military), or in firemen, which were employed to limit population movements from areas where COVID-19 incidence was very high, as well as in border control, particularly in the first months of the pandemic, due to a lack of supply of adequate personnel protective equipment (PPE), and who were performing such tasks without it.

There are no geographical limits. This means that cases declared according to the criteria mentioned previously, even in areas of the country where COVID-19 has had a low incidence, COVID-19 is recognised as an OD in the above-mentioned professionals.
In other sectors, as a rule, COVID-19 will not be recognised as an OD in Portugal.

• If yes, what impacts the recognition has on the employee, on the employer, and on the insurer (e.g. compensation coverage)?

If an OD is recognised in Portugal, all the sick leave period, be either at home or in the hospital, is fully supported by the Social Security system. This support, financial or by other means, is provided since the first day and includes full payment of all drug therapy, and, if that is the case, hospitalisation, recovery at a rehabilitation clinic, or at home. Medical and nursing expenses, and any other complementary therapies that the patients may need, such as kinesiotherapy in a hospital, in a rehabilitation clinic or at home.

If there is not a full recovery of the disease due to COVID-19, and there are some sequelae from it, the patient will have a temporary, or permanent, recognition of handicap, or impairment, which is established by law and in accordance with the National Impairment Table (TNI).

The employer does not have to pay any amount specifically for an OD that has been recognized in his enterprise or establishment, which also includes COVID-19. This aspect concerns, mainly, private hospitals, rehabilitation clinics, labs or ambulances. All the charges that are monthly paid by the employer to the Social Security system, contributes to cover all the expenses incurred with the diagnosis, treatment and recovery of any OD.

In case COVID-19 is considered an accident at work by a private insurance company, which will be a rather exceptional situation, as it may be the case in non-HCW, apart from security officers, the same situation will apply to the employer but, in this case, the insurance company will be responsible to cover all the costs: drug therapy, hospitalisation, rehabilitation at a clinic or at home, medical and nursing expenses, and complementary therapies that patients may need, such as kinesiotherapy at a hospital, clinic or at home.

As a final comment, the Public and Local Administration, are usually self-insured. There are, however, some situations where the insurance is provided by private companies.

• If not, what measures are applied to the situation when an employee is infected at work by the virus and develops the Covid-19 disease?

If an employee is infected at work by SARS-CoV-2, and develops COVID-19, he is fully covered by the National Health System (NHS) regarding treatment and rehabilitation.

This coverage includes the payment of the sick leave until full recovery, full medical and nursing expenses, and eventual hospitalization. In case a medical therapy is prescribed by a GP for COVID-19 it will be partially reimbursed by NHS (between 37 and 69% of full cost, exceptionally up to 90% of full cost) according to the different classes of drug reimbursement that are determined by the Minister of Health.
The study on the current state of recognition of COVID-19 as an occupational disease in the Slovak Republic

doc. MUDr. Oto Osina, PhD

1. Legal framework of reporting and confirmation of occupational disease COVID-19 in Slovak Republic.

In Slovakia, laws and regulations make it possible to confirm all infectious diseases as occupational diseases for all employees working in an infectious environment. In annex 1 to Act No. 461/2003 – Social security act, is the List of occupational diseases. In this list are communicable and parasitic diseases other than tropical diseases and zoonoses, in point 24. Under this law, we may confirm, report and propose compensations for diagnosed occupational disease COVID-19. Generally one-off compensation payments can be proposed for the acute form or the chronic form or both forms of occupational diseases.

Reporting units, wich report occupational diseases and propose the compensation are the clinics of occupational medicine and clinical toxicology, where work medical doctors with specialisations of occupational medicine.


In Slovakia, the first case of COVID-19 was confirmed on 6 March 2020 in Bratislava. It was a 52-year-old man who fell seriously ill after contact with his son who was return from Italy. The son and wife of this man had asymptomatic form of COVID-19.

On 12 March 2020 the government has declared the crisis situation on whole territory of Slovakia. Till the 31 March 2020 we had 400 confirmed cases of COVID-19.

One month later, on 6 April 2020, the government adopted an amendment to the Act 355/2007 on the protection, promotion and development of public health, based on the deteriorating situation. In this act, during the crisis situation, was stopped most activities of the clinics of occupational medicine and toxicology and
providers of OHS, except initial and periodic examination of healthcare workers. Occupational medicine clinics had to subordinate their bed parts and outpatient departments, doctors, nurses and other health professionals to the COVID-19 emergency departments, on the orders of the hospital management. This step had a negative impact on the confirmation and registration of occupational diseases. Since then, the activities of occupational medicine clinics have been very limited in terms of reporting, registering and proposing compensation for all occupational diseases.

The society of occupational medicine had informations that many healthcare professionals had overcome the clinical form of COVID-19 during the spring 2020. From this reason we expected that some cases of COVID-19 we will confirm and report as the occupational diseases, during autumn.

We were surprised, healthcare professionals and other employees who were directly exposed to the virus and had the clinical form of COVID-19 did not apply their right to recognition of an occupational disease. The situation was probably due to a lack of information, a pessimistic mood throughout society, an underestimation of the epidemiological situation and underestimation of the severity of COVID-19. Members of the Society of Occupational medicine discussed and prepared more exact methodologies for confirming COVID-19 as an occupational disease, based on this situation. These activities took place during the summer and autumn of 2020, and in December we sent the Ministry of Health complete material as a Guideline of Clinical Occupational Medicine for the recognition of COVID-19 as an occupational disease. This guideline was published in January 2021 and from this time more the healthcare workers are interested about possible professionality of their COVID-19.

Till the 28 February 2021 we had in Slovakia 592563 positive tested inhabitants and 7186 deaths. We don’t have exact information about death number of healthcare workers.

3. Actual situation in all sectors and on whole territory of Slovakia

We can currently report occupational disease COVID-19 in Slovakia under the following conditions:

a) The workers must have clinical manifestations of the disease and laboratory-verified diagnosis of COVID-19 by PCR test.

b) The workers had work contact with a sick person with COVID-19 or infectious material, resulting from the job description or as part of the performance of work tasks or work activities. This contact was in the incubation period of this disease (14 days before the onset of symptoms). The description of working conditions and the related tasks must confirm contact with the infection and all facts must be documented. Confirmation of contact is prepared by Regional health institutes on the
basis of epidemiological information from the employer. The employer can use his own hygienists or occupational health and safety service for this purpose.

c) If a worker has been tested positive for COVID-19 but is free of clinical symptoms of COVID-19, or the worker has been shown to have community-based transmission, it is not an occupational disease.

Examinations of workers with suspected COVID-19 are performed on the outpatient departments at clinics of occupational medicine.

By the end of February 2021, on the Clinics of occupational medicine were examined 103 workers for occupational COVID-19 suspicion on whole territory of Slovakia. Most cases were in the central part of the country, Banská Bystrica Region - 60 cases, followed by the eastern part, Košice Region - 37 cases and the northern part, Žilina Region with 6 cases. We don’t have information from the western part of the country, from the Bratislava, Trnava, Nitra and Trenčín regions. The Clinic of occupational medicine, which covers these regions, was subordinated to the infectology clinic and currently does not perform occupational medicine activities.

From all number 103 examined workers, in 92 cases we requested confirmation of work contact with sick person or infectious material.

From all cases were confirmed 5 occupational diseases COVID-19. We expect that all 103 cases after confirmation of contact will be recognized and reported as the occupational diseases.

All cases of COVID-19 examined for suspected occupational disease came from the sectors of Human health and Social work. Most cases of COVID are in the professions of nurse, medical doctor and other healthcare professional.

In Slovakia, COVID-19 is the occupational disease and the reporting units (occupational medicine clinics) at present report acute forms of COVID-19 as an occupational disease and propose compensation for acute forms. In the future, when some of the reported cases go to the chronic stage, we will propose compensation for permanent consequences.

The registration of positive persons COVID-19, the search for their contacts are performed by Regional public health institutes throughout the territory. This database can be used to confirm or exclude contacts of the sick employee with positive people on workplace or in other place outside employment.
4. Impacts on the employee, on the employer and on the insurer.

Registration and reporting of the occupational disease COVID-19 has a positive effect on the employee. The compensation may partially cover loss of pay during incapacity of work. In the event of permanent inability for work after COVID-19, the employee can claim additional social insurance benefits.

The Social Insurance Agency, which is the state institution, pays one-off compensation for occupational diseases to employees who had a recognized and registered occupational disease COVID-19 under act No. 461/2003 coll. The government in November 2020 adopted an amendment to the Act 461/2003. In this act government increase support healthcare workers temporarily unable to work due to confirmed COVID-19. Together with the sickness benefit from reason of COVID-19, the healthcare worker will therefore receive approximately 80% of gross income. In this case the work contact with a sick person with COVID-19 confirm only employer.

The employer has no additional financial costs associated with compensation for occupational disease COVID-19. The permanent inability of some healthcare workers after COVID-19 may cause that employer will restrict some of his services. The situation is caused not only due to COVID-19, but also by a long-term shortage of qualified health workers, especially nurses and medical doctors.

5. Discussion and problems

On the national level COVID-19 is generally accepted as the occupational disease in groups of health professionals, health associate professionals, social professionals and personal care workers.

The current national discussion on COVID-19 as an occupational disease is taking place on two levels. The first level is a professional discussion of specialists from occupational medicine. The main problems of this discussion are the less severe forms of COVID-19, which do not meet the all clinical criteria needed to confirmation an occupational disease. The prevailing view is that for milder forms of COVID-19, most be of the clinical criteria set out in the guidelines for the recognition of COVID-19 as the occupational disease, should be met. Other discussed problem is worse communication and cooperation with general practitioners, which don’t sending the patients with suspicion on occupational disease to clinics of occupational medicine.

The second level is the discussion between the representatives of occupational medicine and representatives of the National Institute of Public Health, who prepare proposals for amendments to laws for the Ministry of Health. Not all suggestions that are based on experience of occupational medicine and OHS providers, are accepted by the Ministry of Health and the approval process is long.
The discussion between the representatives of occupational medicine, National Institute of Public Health and the Confederation of Trade Unions of the Slovak Republic on the theme of COVID-19 as the occupational disease, is only sporadic.

In the event of any problems during diagnosis, exposure verification or in case of disagreement with the conclusions of the occupational medicine clinic, the employer, employee, Social Insurance Agency or others may appeal. The highest professional medical institution for dealing with appeals in occupational diseases is the National comission for occupational diseases, which was created on Ministry of Health.
Covid-19 as occupational disease in France

Dr Zylberberg Jean-Louis

On the 22 of April 2020, the Health Minister Olivier Véran said at the French Parliament: «...The COVID-19 will be systematically and automatically recognised as occupational disease for the health care workers...» and the other workers would be subject to «classic recognition».

Nearly one year after this declaration, what is the situation in France?

First, since 1919, year of birth of the first table of occupational disease, recognised (Lead pathologies), only the worker in a private enterprise (except the workers of the agricultural sector who benefit specific tables of occupational diseases), can benefit of the «presumption of imputability» and not council worker or civil servant (police officer, etc.). It means, only employee of the private sector and since a 2000 case law for hospital public service workers, don’t have to demonstrate that the COVID-19 disease is occupational if the disease is in a table of occupational disease.

The project of a new table of occupational disease (number 100) was discussed on the 7th of July 2020, in the commission of occupational diseases of the National Orientation Council of Work Conditions («COCT»). This commission is composed of representatives of employers and unions, government officials (Ministry of Labour, Agriculture Ministry, etc.), other institutions (Social Security, Agencies, etc.). Unfortunately, this project of table took only account of severes respiratory forms of the COVID-19 (necessity of oxygenotherapy or other ventilatory assistance) and not other clinical forms. The limitative list of occupational expositions concerned only the medical and socio-medical sectors. Despite the Unions protestations during the debate of the commission of occupational disease, the 100th table of occupational disease (the 60th table occupational disease for the agriculture sector) was inserted in the Social Security Code, on the 14th of September 2020.

For all the employees of retail sector, transport sector, cleaning sector, etc., they can’t benefit of this table and have to run «the medico-administrative marathon» of the complementary system of recognition of their disease. But this system needs that their disease is severe (at least 25% of incapacity) and they have to demonstrate that the link between their disease and their occupational expositions is «direct and essential». A national committee, composed of a hospital occupational diseases consultant and a Social Security practician, will decide.
At the end of December 2020, 15,000 applications for recognition of occupational disease had been registered by Social Security, 10,000 retained and the rest in work accident. The complementary occupational disease recognition system had received 33 files.

When the first Covid containment occurred in the mid March 2020, a lot of trade unionist try to use the regulatory labor law (the collective right to alert facing a serious risk or the individual right of withdrawal) because the means of prevention against this biological hazard were not set up in the enterprises. But the fear climate, the pressures on employment and also the false interpretations of the right of work by the Administration of the Labour Ministry avoided the trade unionist actions.

The other strategies used by the trade unionist were the appeals to the Courts for interim relief.

On the 3rd of April 2020, the Lille Court (north of France), seized by a union of workers from a home help association and by a labor inspector, ordered the execution of the various obligations to preserve health and safety requested by the labor inspector as a matter of urgency: Contact before each intervention (at the earliest one day before and at the latest before the intervention) with the client and/or the client’s family by the association at the end of inquire about the presence of symptoms or a positive diagnosis for the Covid-19 virus; feedback the day before and at the latest before the intervention in order to inform the employee of the existence of a proven risk or not of contamination and to check with from him if he still has all the necessary personal protective equipment and this in accordance with the specific texts on the prevention of biological risks in the workplace.

On the 14th of April 2020, the Nanterre Court (near Paris) seized by a union of workers from an Amazon warehouse and « the Friends of the earth” association (association created in 1970 whose goal is to protect the environment, the climate and defend human rights) ordered the executions to proceed, with the involvement of staff representatives, to the evaluation of occupational risks in connection with the Covid-19 epidemic in all warehouses and the implementation of preventive measures. Pending the implementation of preventive measures, the court orders within 24 hours to restrict the activity of its warehouses to the sole activities of receiving goods, preparing and shipping orders for food products, hygiene products and of medical products, subject to a penalty of 1,000,000 euros per day of delay.

On the 7th of May 2020, the Havre Court (Normandy), seized by a union of workers from Renault automobile manufacturing plant, ordered the execution of resume the information-consultation of workers’ unions in accordance with the regulations and suspend the project on organizational modalities for the resumption of production during the Covid-19 epidemic, while the information-consultation of trade unions is regularized and to suspend the resumption of production.
In the same time, the trade unionist helped the workers infected by the new coronavirus SRAS-CoV-2 to declare accident at work. Indeed, the reglementary definition suppose three conditions: a bodily injury, a fact linked to work and sudden event. Despite these three conditions were met, the Safety Security systematically refused without inquiries and suggested to declare an occupational disease before the 14th of September, on their special website “declare-maladiepro.ameli.fr”. In the hospital public service, some exceptions to this policy of non-recognition of work accidents were possible. For example, nurses and anesthetists were recognized as an occupational accident when they were infected following the intubation of infected patients but not in the private sector.

By an order of Decembre 18 2020, Sars-Cov-2 was classified as a pathogenic biological agent group 3. Since 2017, the workers exposed to pathogenic biological agents group 3 or group 4 have medical monitoring of their health reinforced by occupational doctors or nurses. It means that their employers must refer them to the occupational health service every two years and not every five years. But in 2021, no occupational health service offers employers this interpretation of the new SARS-CoV-2 classification.

The national interprofessional agreement (ANI) of November 26, 2020 for the successful implementation of teleworking was signed by some trade unions (the last one was signed in July 19 2005). In this agreement, there is no employers obligations to finance, if teleworking takes place at the worker’s home, energy costs and internet service subscriptions, etc. except if there is a company agreement. The risks of isolation and loss of social ties with colleagues and management, the risks loss of meaning or utility should be anticipated but unfortunately, different inquiries in France conclude that 31% of teleworkers felt a sense of isolation in 2020 associated with an increase in their consumption of alcohol or psychotropic drugs.

ANNEXES: French Epidemiological Investigations

Healthcare workers

Since the 22 of April 2020, «Santé Publique France» (national Health agency) has been set up an epidemiological surveillance to collect the healthcare professional COVID-19 cases who work in private ou public institutions. Between the 1st of March 2020 to 8th of February 2021, 67 871 healthcare workers were infected by Sars-CoV-2. Nineteen deaths were registered: five physicians, five assistant nurses, one nurse, two classified «other healthcare worker» and six non healthworker workers (for example, in Paris, in april 2020 one service technician). None death was registred since mid-december 2020. For the last six weeks (end of december to the beginning of february), the proportion of healthworkers infected varied to 0% to 3,7% of the healthworkers (the majority in two regions of France, north and east).
Agriculture sector Workers

Following the COVID-19 epidemic, «Santé Publique France» has mobilized to launch a survey of 48,000 participants from the Coset-MSA (which concerns workers and ex-workers in the agricultural world (farmers and employees) and Coset-Independent cohorts (which concerns workers and former self-employed, non-agricultural: artisans, traders, liberal professions), in order to study the impact of the COVID epidemic -19, on the work situation and the health of self-employed workers and active workers in the agricultural world.

For the Coset-MSA and Coset-Indépendants cohorts, recruitment was carried out in 2017-2018, by inviting a large sample of people affiliated in 2016 to the “Mutualité Sociale Agricole”(the Social Security faor the agriculture sector) and to the Scheme providing social protection for self-employed workers, to join the program by completing a questionnaire on their health, professional situation, working conditions and career history.

The epidemiological assessment of the data collected in these questionnaires will be published in 2021.

Study of socio-demographic factors, behaviors and practices associated with infection with SARS-CoV-2 (ComCor) published on the 8th of December 2020

The objective of this study is to identify the socio-demographic factors, the places frequented and behaviors associated with an increased risk of infection with SARS-CoV-2. It’s about also to detail the places and circumstances of contamination as described by the people who know or suspect where they were infected or by whom they were infected.

The Pasteur Institute analyse 30,330 questionnaires (8.2% questionnaires that were returned) corresponding to patients who had their onset of symptoms, or their test in the absence of symptoms, between October 21st and November 3rd 2020, i.e contamination likely taking place between October 17 and October 30, 2020.

For out-of-home contaminations (65% of contaminations when the source person is known), these are primarily contaminations in the family circle (33.1%), then in the professional environment (28.8%), and finally in the friendly environment (20.8%). Meals play a role central in these contaminations, whether in a family environment, friendly, or to a lesser degree professional. Shared offices are also important in the workplace. The mask was neither worn by the source person nor by the index case in 93% of cases of contamination in the private sphere and 45% in the professional sphere, including when the source person was symptomatic. And the contact took place indoors (windows closed) in about 80% of cases.
Covid-19 as an occupational disease

Report by Fabio Strambi

Thanks for the fruitful cooperation to:
A. Fattorini, G. Marchese, R. Montagnani

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

Italy was the first Western European country to be seriously affected by Covid-19 right from the beginning of 2020. It spread above all through the Northern regions of the country affecting the hospitals of the small towns and the city of Bergamo. There were many victims amongst whom were the elderly suffering from poor health, but most especially doctors and nurses who, without adequate training and protection, found themselves confronting the dramatic situation of the spreading virus. The unpreparedness of the country and the reality of local areas to cope with the pandemic allowed the virus to spread quickly and attack all levels of the population without having the protection of prevention, hygiene and safety measures, occupational medicine, and the usual safety measure used in hospitals, being applied. The measure imposed of an almost total lockdown of businesses and the ban on socializing in the country, together with the arrival of the warmer weather meant there was a pause in the spread of Covid-19. However, the spread of the virus started again in Autumn affecting all the regions in the country up to the present during which time we are also witnessing the arrival of the new variant of the virus which has a higher rate of infection. The epidemiological picture is clearly shown in the John Hopkins University observation (1): in yellow in Fig.1 shows the trend of the pandemic which in February 2020 produced more than 2.7 confirmed cases of which 93,577 deaths in Italy meant it was the seventh country in the world with the highest number of victims.

![Fig.1](image-url)
If yes, in which sector, activity, geographical area, company, etc.? Please describe the case(s) in detail, also including any limitations e.g., Covid-19 recognised as an accident not a disease.

The Italian Insurance Institute against Accidents at Work, INAIL, classifies and protects infective and parasitic diseases as accidents at work because it equates the virulent cause with the violent one; therefore, in Italy, if Covid-19 was contracted while at work it is classified as an accident at work and not as an occupational disease. INAIL insurance protects employees who have an employment contract, dependants, subordinates, professional sportsmen/women, managers and students. In the present pandemic situation, the area of protection is being concentrated mainly on health workers who are exposed to a high risk of contagion and to other personnel whose work means they are in frequent contact with the public: people who work in reception, cashiers, salesmen, market stall holders, personnel who are not health care workers but who work in hospitals as technicians, support staff, cleaners and ambulance drivers. (2) The graph below, Fig.2, shows the number of Covid-19 cases reported to INAIL in 2020 (3) and their distribution in the various areas of the country with a notable prevalence in the northern regions.

Fig.2  Italy 2020: Covid-19 notifications of accident et work; percentage by geographical area

Of the 131.00 reported accidents 433 (Fig.2) were affected fatally. These occurred above all in the first wave of the pandemic, 73.8% in March and April. 83% of cases were men mainly from the north of Italy (Lombardy 37.6% e 12.1% in the north east). The professional category most affected by deaths are the technicians/nurses and doctors of which there are 10,0% reported cases (61% nurses of which about half are women) doctors 6,8% (one death in 10 is female). These are followed by social workers at 5.1% (about half are women), non qualified health workers (auxiliaries, porters, stretcher bearers, of these 44% are women), 3.9% the carers 2.9% (58% are women, toxicologists and pharmacists 1.9%. Other categories less affected are: administrative personnel, drivers, sales staff, administrative and health sector directors and managers, mechanics, security and supervision staff and warders. Specialists in general building maintenance and precision mechanics, restaurant, managerial, commercial and banking personnel.
1. If yes, what impacts the recognition has on the employee, on the employer and on the insurer (e.g. compensation coverage)?

When there is a confirmed case of coronavirus (SARS-CoV-2) in the workplace (4) the doctor writes an accident certificate and sends it electronically to INAIL who insures accident coverage, even if the subject is not at work, with no cost to the employer in both the private and public sector. The employers in both the private and public sector must communicate the accident/illness to INAIL (5). Following the accident report the information is also sent to the Public Service of Hygiene and Safety Prevention at Work who are responsible for making sure the norms of prevention are carried out in the workplace. Also Labour Inspectorate has certain duties to ensure safe working conditions in specific production sectors. Inspection staff will carry out an inquiry on the accident which could result in a report with safety prescriptions for a safe workplace. An eventual sanction is applied if there is a transgression of the prevention norms as well as a penal court case which could result from the summons.

Cover starts from the first date of abstention from work because of contagion as indicated in the medical certificate or from the first day of absence from work coinciding with the start of the period of quarantine if the infection is confirmed after the start of quarantine (2). Workers who are asymptomatic and tested negative but who are in quarantine due to public health restrictions because for example, they were in close contact with cases of from Sars-CoV-2 and therefore could be carriers of the incubating virus, do not benefit of the INAIL cover but will have the same economic benefits which are applied during leave of illness (4). Insurance cover is also guaranteed in cases where precise identification of cause and condition of Covid-19 contagion is a problem. One therefore assumes the origin to be professional taking into consideration the type of job/work and other indicative evidence. It is as well to remember that the high risk of contagion for people working in public health is evaluated using territorial epidemiological data (6). As well as people working in the health service, the assumption that people infected with Covid-19 in their place of work is also valid for those whose work means they are in constant, or at least in frequent, contact with the public as indicated above (2). For all other workers proving the origin of contagion is up to the individual concerned. Cases of contagion during journeys to or from work are also covered. These are considered commuting accidents (7). Workers whose health is compromised as a result of Covid-19 are paid an income or compensation by INAIL based on the resulting disability. Where the injury is caused due to lack of responsibility by the employer who did not follow the norms of prevention and security in the workplace, INAIL can recover from the employer the expenses incurred in favour of the employee with the disability or pathology. In the case of death by Covid-19, the worker’s family is given money one off from the Fund for victims of bad accidents while at work. This assistance is also given to workers who are not insured by INAIL (8). To sum up the financial assistance given to workers affected by Covid-19 by the INAIL board: daily compensation for total incapacity; compensation for fundamental biological damage; a cheque one off in the case of death; an income to survivors; a cheque for permanent personal
assistance (APC); a cheque for the unemployed; a refund for medical expenses (2). When a worker becomes symptomatic and above all when the result of a Covid-19 test is positive all the measures required in the national and regional norms are enforced to protect worker’s health, make the company safe, trace other contacts so as to avoid the diffusion of the virus and check the subject on return to work after recovery (9). The doctor in charge has a decisive role visiting the worker to determine fitness and negative infectivity.

Description of a worker with long term Covid-19

This is an example of an actual case in a medium size engineering company in the centre of Italy. The public health department allowed some workers who were infected with Covid-19 to suspend isolation 21 days after the appearance of symptoms and after a week without symptoms, as provided in the Ministry of Health’s circular (10), they returned to the same job they did prior to contagion even though the Covid-19 molecular test/tampon showed they were still positive. Both the company and the occupational health doctor did not allow the workers to return to work as the test was not negative as required by the norms (11). The workers found themselves in limbo without protection, the period covered by insurance having finished. They could not return to work and could only do “smart working”. The region having intervened (12), the case was rectified asking the family doctors to extend the health certificate until the result of the molecular tampon was negative therefore guaranteeing the workers cover until they were able to return to work.

2. If not, what measures are applied to the situation when an employee is infected at work by the virus and develops Covid-19?

The national health service in Italy guarantees all citizens the right to medical care and hospitalisation without the patient being charged. In the case of Covid-19 all citizens, including the self-employed and freelancers who are not insured by INAIL, are guaranteed care before, during and after illness. There are also support measure to help with income, compensation for employees, the self-employed (freelancers included) who, as a result of the Covid-19 epidemiological emergency have had to stop (4), reduce or suspend their work. For public or private sector workers who are considered to be particularly at risk because of specific pathologies, the so called “fragile”, hospitalisation is provided for the period required.
3. What is the current national discussion on the issue (e.g., trade union demands, employers’ and other stakeholders’ position, structured or non-structured discussion)?

At the moment, discussion about the protection of workers who have Covid-19 is not so much about the recognising Covid-19 as an insurable occupational disease instead of an accident at work, but the necessity to guarantee the same protection to the millions of workers who are not insured by INAIL and do not therefore, have access to income or benefits (7). Considering the very high Covid-19 rate of injury, Fig.1 many employers’ associations have expressed their worries not only about the human aspect but the eventual possibility that INAIL may make the companies pay for the compensation paid out to the infected workers as is stated in cases where there is a failure to carry out security measures in the work place by the employer. It should be mentioned that law n° 33/2020 (13), expects companies – both business and productive – to follow the appropriate protocols or guide lines to prevent or reduce the risk (9) of contagion. It has given employers an extra and valid method to conform to the norms of prevention; for some production sectors, for example logistic/transport and building, specific protocol has been supplied (15). In any case, in order to let employers know they understand their worries, INAIL has produced a circular (14) which supports giving accident benefits to a Covid-19 case and does not mean to attribute any blame on the employer. It is understood, and the circular confirms this, that accident benefits are provided even if the worker is to blame and there is no responsibility on the part of the employer. Responsibility by employers is assumable only in cases where the law has not been followed or from conditions due to new experimental or technical knowledge, which, in the case of Covid-19, are also in the protocols and the government guide lines (15). It seems logical to suppose that the Institute will ask the company for money back only in cases where there is “proven transgression” by the employer. An important trial supporting businesses, employers and workers in order to guarantee productivity in safety, in special reference to the risks of Covid-19, is in progress in Tuscany called “Buona Pratica del Castello di Casole d’Elsa” (Good Practice award by the Bilbao Agency). The beautiful town of Monteriggioni (16), on the old Francigena road in the province of Siena, chose this good practice protocol to restore its ancient walls.
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COVID-19 as occupational disease in Latvia

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COVID-19 pandemic has raised several issues on recognition of this disease as occupational disease in many countries including Latvia. This report covers general issues concerning recognition of infectious diseases as occupational diseases, discussions among policy makers, employers and experts during pandemic, changes in legal framework for diagnostics and recognition of COVID-19 as well as current situation in Latvia (February 2021).

Situation before COVID-19 pandemic

The System for Occupational Safety and Health (OSH) at work in Latvia is primarily set by the main legal document in this area in Latvia – Labour Protection Law [1] (note: instead of the commonly used term “Occupational safety and health” in Latvia term “Labour protection” (“Darba aizsardzība” in Latvian) is used as remain from the former Soviet Union). The Article 13 of this Law sets out the requirements for investigation and registration of accidents at work and occupational diseases. It requires the employers to ensure investigation and perform registration of accidents at work and occupational diseases according to requirements set by Cabinet of Ministers. It also authorises Cabinet of Ministers to establish national procedure for the investigation and registration of occupational diseases, the list of occupational diseases, as well as the list of factors causing occupational diseases.

According to this requirement, Regulations of Cabinet of Ministers nr.908 “Order of investigation and reporting of occupational diseases” were adopted on 06.02.2006 [2]. These regulations describe the order for reporting and registration of occupational diseases (OD) and establishes the National list of recognised occupational diseases that is almost direct translation of Annex I and Annex II of Recommendation 2003/670/EC. Annex I of these Regulations also contain main types of diseases that could be caused by the occupational risk factors (as listed in Annex I and Annex II of the Recommendation 2003/670/EC). In other words, current occupational diseases system allows linking almost any disease (including COVID-19), as being occupational disease, as far as there is a clear link between work conditions featuring any of the workplace risk factors (as mentioned in Annex 9 of National regulations or Annex I and Annex II as mentioned in Recommendation 2003/670 /EC). This link shall be established and approved by special authorised commission of occupational physicians. The regulations also describes the establishment of such commissions and requirements for their work. Currently the actual diagnose is confirmed (so the occupational disease is
recognised as occupational) by commission of occupational physicians (so far there is only one working at Centre of Occupational and Radiological medicine). Commission then is responsible for evaluation of clinical status and available information (including test results, evidence on work experience and exposure). Commission has the rights to ask for further investigations and tests as well as for opinion from State Labour inspection on working conditions (so-called hygienic evaluation of workplace) of the particular patient. There are minimum quality requirements for the commission – it should include at least two certified occupational physicians, one certified occupational health and safety expert with medical background and representative from State Labour inspection. There are also rights reserved for participation with vote for representatives of State Social Insurance agency (institution administrating compensations for OD patients) however, in practice they do not participate. Individual occupational physician can make diagnose of occupational disease but it bears no official consequences in terms of registration in registry and compensations to worker.

As to occupational diseases caused by biological risks, according to Annex I (List of occupational diseases) following groups of such diseases could be recognised:

- infections and parasitic diseases pursuant to the infection with which the employee was in contact during the hours of work: amebiosis, brucellosis, erysipeloid, tick-borne encephalitis, yersiniosis, Lyme disease, leptospirosis, ornithosis, Q fever, tetanus, tuberculosis, tularaemia, viral hepatitis;
- other infections which have originated while fulfilling professional duties in the field of health care, prophylaxis and social work or other services, and in the origin of which importance of working environment risk factors has been proven (HIV/AIDS, Hepatitis B, Hepatitis C, tuberculosis);
- dysbacteriosis, skin and mucous membrane candidamycosis, visceral candidiasis.

There are no direct mention of diseases caused by coronaviruses as only examples of some OD are mentioned, however in Annex V “Classification of causing factors” there is a specific mention of coronavirus group (factor: 3200060000, Coronaviridae family).

As to the registration requirements for employers, these are described in Regulations of Cabinet of Ministers nr.950 “Procedures for Investigation and Registration of Accidents at Work” (adopted on 25 August, 2009) [3] mainly describing procedure for accident investigation but also including so called “acute occupational diseases” or incidents with potential for development of infectious diseases (e.g. tick-borne encephalitis or viral hepatitis). The requirements for cases to be investigated and registered foresees “that accident is an extraordinary incident which has occurred in the workplace within one working day or shift, after which health disorders have been caused to a person or the probability of health disorders occurring exists (risk for infection)” (Article 2). Such definition therefore includes also several occupational diseases, including infectious diseases.
There is also compensation system established for registered occupational diseases in accordance to law on compulsory social insurance in respect of accidents at work and occupational diseases [4] that is in force since 1997. The insurance premiums are paid by employer for each of his employees. Some groups of workers are excluded from the system, like self-employed persons. Currently (from 2021) the amount of insurance premium paid is 0.66% from salary. It doesn’t differ for different industries or job types.

In summary – the existing legal framework in force before pandemic allowed COVID-19 to be registered as occupational disease if the link between exposure and disease could be established using two different approaches. This, however, does not apply to military personnel and internal forces (e.g. police workers) as they are excluded from scope of the Labour Protection Law.

**Changes during COVID-19 pandemic**

With rapid development of COVID-19 crisis and declaration of emergency situation from March 12, 2020 the issue of COVID-19 become an issue (first case of confirmed COVID-19 was diagnosed on March 2, 2020) and there was an understanding that massive number of COVID-19 cases that could be linked with working conditions would create problems for the diagnostic and registration capacity and later, for social security system. Therefore, the Order Nr.103 “Regarding declaration of the Emergency situation” of Cabinet of Ministers were adopted on March 12, 2020 that also included changes in several regulations concerning occupational safety and health [5].

Namely, article 4.56 said: “it shall be determined that contracting COVID-19 is not considered an accident at work according to Cabinet Regulation No. 950 of 25 August 2009, “Procedures for Investigation and Registration of Accidents at Work”, Cabinet Regulation No. 116 of 1 March 2016, “Procedures for Investigation and Registration of Accidents at Work Which Have Occurred to Officials with Special Service Ranks of the Institutions of the System of the Ministry of the Interior”, and Cabinet Regulation No. 42 of 21 January 2020, “Procedures for Investigation and Registration of Accidents at Work Which Have Occurred to Officials and Employees of State Intelligence and Security Services”, and the employer need not perform the investigation and registration of such case”.

Such decision, even if understandable and meant to reduce administrative burden of employees, were technically unfavourable to employees that were infected with SARS-CoV-2 during their professional duties. Another argument behind it was that during pandemic, clear exposure route in many cases were difficult to prove. In practice, however it meant that, if, for example, a health care worker developing COVID-19 after direct contact with confirmed COVID-19 case would not qualify for recognised occupational disease (as this particular event would not be registered) and would not receive compensation for treatment and rehabilitation in case of long term health problems. However, this Order did not limit the functioning of regulations for recognition of occupational diseases meaning that if the causal link could be proven, such case could be recognisable as occupational disease. This
problem was widely discussed and supported as issue by society and trade unions (especially from health care sector).

Another important discussion were observed regarding the regulations on occupational diseases as coronaviruses were not specifically mentioned in Annex 1 “List of occupational diseases” rising concern that COVID-19 cannot be recognised as occupational disease thus limiting proper treatment and rehabilitation for certain groups of workers in future.

Changes in regulation during COVID-19 pandemic and current situation

In response to identified problems and discussions, small informal working group was called together to discuss aspects of COVID-19 as occupational disease with representatives from Ministry of Welfare (primarily responsible for occupational safety and health), State Labour inspection, Ministry of Health, Institute of Occupational safety and environmental health and Centre of Occupational and Radiological medicine. The decision of this group was to suggest several small changes in legal regulations to make requirements of infectious diseases as occupational diseases more understandable and clear.

First, additional phrase was added in Regulations of Cabinet of Ministers nr.950 “Procedures for Investigation and Registration of Accidents at Work” (adopted on 25 August, 2009) in Article 2 [3] adding the following sentence:

- “Infectious diseases could only be recognised as occupational accident if such disease is linked with specifically identifiable extra ordinary event during the work and this event has direct causal relationship with this particular disease” (note: no official translation is available yet).

This amendment was accepted as Regulations of Cabinet of Ministers nr.351 “Changes in regulations of Cabinet of ministers Nr.950 “Procedures for Investigation and Registration of Accidents at Work” (adopted on 25 August, 2009) (adopted in 4.06.2020, in force from 6.06.2020) [6].

Second, additional word was added in Regulations of Cabinet of Ministers nr.908 “Order of investigation and reporting of occupational diseases” (adopted on 06.02.2006) [2] in Annex I of Regulation. Specifically in subparagraph 2.2. word “COVID-19” was added and now the subparagraph is worded like this:

- “other infections which have originated while fulfilling professional duties in the field of health care, prophylaxis and social work or other services, and in the origin of which importance of working environment risk factors has been proven (HIV/AIDS, Hepatitis B, Hepatitis C, tuberculosis, COVID-19).

This amendment was accepted as Regulations of Cabinet of Ministers nr.352 “Changes in regulations of Cabinet of ministers nr.908 “Order of investigation and reporting of occupational diseases” (adopted on 06.02.2006) (adopted in 4.06.2020, in force from 6.06.2020) [7].
Conclusions

Currently there are no restrictions or limits to recognise COVID-19 as occupational disease in Latvia either using the registration through occupational accident (including ill-health or occupational diseases) system or using traditional occupational diseases notification and recognition system.

However, so far there are no registered and recognised cases of COVID-19 as occupational disease in Latvia. Partly this could be explained by the relatively long registration procedure (6-9 months) of occupational diseases that are even longer under emergency conditions. Another reason is that typically, patients are applying for recognition of their health conditions as occupational disease after the traditional health care system benefits and options are used (e.g. 6 months of paid regular sickness leave etc.) and chronic conditions have developed. Also enquiries within Labour inspection showed that there has been no registered cases of COVID-19 exposure as potential occupational accident.

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   Note: English translation DO NOT include latest amendments.
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