Cross-cutting introduction to Accidents at Work and Occupational Diseases (Table VIII)

There is a long history of social security intervention in the event of accident at work or occupational disease. In part this is because the development of industrial economies brought about unsafe working environments, the need to operate dangerous machines and the routine exposure of workers to dangerous minerals and chemicals. Accidents, indeed fatalities, at work (or on the way to or from work) were relatively common but the individual worker was frequently not only vulnerable to injury but could only seek redress directly against his employer. In these circumstances workers were often left without compensation and had no alternative, if subsequently unable to work, but to rely on assistance from the Poor Law or private charity.

The principle which emerged was one which took the injury at face value and did not seek to apportion blame to either the employee, the employer or even a third party. The over-riding priority was to provide financial support to the injured worker and his/her dependants. The liability to provide compensation was placed upon the employer under statutory regulation.

Not all countries have separate systems in place to cover the risk of accidents at work and occupational diseases. Often, this risk will be catered for through other, related systems. Indeed, one particularity of the branch of accidents at work and occupational diseases is that it has links to several other social security risks, i.e. healthcare (Table II), sickness cash benefits (Table III), invalidity (Table V) and survivors (Table VII). As a general rule, where specific provision is made for the risk of accidents at work and occupational diseases, arrangements are more favourable compared to those governing compensation in case of non-occupational injury (e.g. less stringent conditions, higher benefit amounts etc.).

The scope and levels of compensation vary from country to country but it is conventional for there to be five tiers to a fully developed benefit structure:

1. Medical and hospital treatment. In the event that medical treatment is not available free at the point of access through a national/universal health care scheme there will usually be prescribed and capped scale of costs;

2. Temporary incapacity. During a period in incapacity earnings are maintained at a prescribed proportion of previous wages;
3. Permanent total incapacity. This may result in a pension or a lump sum calculated on the basis of previous earnings and may be further increased if continuing care is required;
4. Permanent partial incapacity. This is usually a pro-rata share of the full incapacity pension or grant determined according to a prescribed and fixed schedule related to the severity of injury;
5. Fatal cases. A pension or lump sum calculated on the basis of previous earnings, operating within minimum and maximum limits.

Where there is disagreement about the extent or consequences of injury, or dispute about the level of payment, mechanisms usually exist to provide for arbitration.

The majority of countries not only cover accidents sustained at work or while working, but also accidents occurred while travelling to or from work.

Most countries have a prescribed list of occupational diseases and this can make the claim for compensation easier than might otherwise have been the case. In countries with a “mixed” system, diseases which are not on the prescribed list may nevertheless result in compensation if the victim can prove the occupational nature of the ailment.

Many industrial injury schemes include or are linked to rehabilitation programmes. In addition to providing prosthetics or other orthopaedic devices they may provide counselling and/or vocational training.

MISSOC Secretariat, March 2012