Occupational Diseases

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Occupational Health Statistics Bulletin 2005/06

The bulletin draws on a variety of information sources to quantify the rates of occupational disease in the UK. None can be considered accurate and some are very inaccurate or misleading.

Overall in 2004/05 approximately 2 million people would have said they believed they were suffering from an illness which was caused or made worse by work. Over 500 thousand would have said they first became aware of this in the past 12 months. This comes from a telephone survey of householders around the country.

This compares with an estimated 22,000 new cases of occupational disease that were seen by occupational physicians and other specialists in 2005. A total of 6,500 claims for industrial injuries disablement benefit were processed in the same year.

Cancer
Based on estimates made 30 years ago, the report claims that between 3,000 and 12,000 cancers deaths each year are of occupational origin. [median estimate = 6,000 i.e. 4% of all cancer deaths]. The ratio of male to female would be 5:1.

Highest frequencies in men would be for lung cancer (est. 2,850), pleural and respiratory cancer (430), bladder cancer (310), leukaemia (230). In women, lung cancer would account for 660 cases of occupational origin.

Cancers, which are compensated under the industrial injuries disablement benefit scheme, number around 100 per year and include leukaemia, asbestos-related lung cancer, lung cancer due to arsenic, nickel, silica etc. exposures, skin cancer due to bitumen and mineral oils, nasal cancer due to chromates, liver cancer due to vinyl chloride monomer.

Asbestos
Based on analysis of death certificates, in 2004 nearly 2000 people died from mesothelioma, and around as many again from asbestos-related lung cancer. 100 people died from asbestosis and over 200 from other types of pneumoconiosis, mostly associated with coal dust and silica.

Bronchitis and Emphysema
Some research indicates that up to 15% of bronchitis and emphysema may be work-related, caused by exposure to dusts, fumes and chemicals. This would account for around 4,000 deaths per year. The number experiencing such problems each year in the population as a whole is estimated to be around 1 million (a work-related rate of 15% would suggest 150,000 cases of work related disease). Epidemiological studies have identified associations between a number of other occupational exposures, including coal dust, cotton dust, grain dusts and endotoxin, flour dust, welding fumes, other minerals – such as silica and man-made vitreous fibres, other chemicals – such as isocyanates, cadmium, vanadium, and polycyclic aromatic hydrocarbons (PAHs) – and wood dust. Coal dust gives rise to approximately 200 claims a year for state compensation.

Musculoskeletal disorders
According to the labour force survey 2004/05 an estimated prevalence of 1 012 000 people in Great Britain suffered from a musculoskeletal disorder which, in their opinion, was caused or made worse by their current or past work. Above average rates were reported by process, plant and machine operatives and skilled trades. Below average rates were reported by managers and administrators.

Stress
The labour force survey 2004/05 showed that around 500,000 individuals believed that work-related stress was making them ill. One in 6 thought their job was very stressful. Diagnostic databases estimate the number of new mental health problems related to work each year is around 6,400. reports were more likely among teachers, nurses and managers.

Occupational asthma; diagnostic incidence = 492 cases per year.
Dermatitis; diagnostic incidence = 3200 cases per year.
Infections; 1578 diagnosed cases per year.
Hand-arm vibration syndrome; between 500 and 850 diagnosed case per year.
Noise induced deafness; less than 1000 new cases per year.

Comment

All sources of estimate and measurement are subject to significant uncertainties. It is quiet apparent that self reported intuitions about the effects of work on health favour a more pesiimistic view than do surveys of clinician diagnoses. However, clinician diagnosis requires the patient be sufficiently motivated to seek help and there are too few specialists with the ability to make a reasoned judgement. Rates based on clinical report will be an underestimate.

The self reported data are probably of no value in exposure estimates except that they indicate the worst possible case. They are of concern only in that if self report became a valid basis for a claim then these are the numbers that should be expected. Detailed examination of the relative rates of disease according to job title or occupation may not be worthwhile.

Industrial injuries compensation estimates are also an underestimate; some valid claims are turned down. The number of claimants is usually around twice the number who succeed.