Disease reporting after the Reporting of Injuries, Diseases, and Dangerous Occurrence Regulations (1995) (RIDDOR) is revised

The Health and Safety Executive (HSE) consultation on amendments to the RIDDOR Regulations was concluded on 28 October 2012 [1]. Within the consultation was a proposal to limit disease reporting to the HSE to 'those resulting from a work-related exposure to a biological agent'.

The current process of disease reporting under RIDDOR is complicated, requiring a doctor to inform the employer via the employee of a disease and for the employer to be aware that the disease if associated with certain types of work must be reported to HSE [2]. As most workers do not have access to occupational health and general practitioners may not have had training to recognize an occupational cause of disease it is not surprising that the chain of events required to enable an employer to complete a RIDDOR report is not completed. There is also a disincentive to do so for the employer, as it may lead to investigation and possible prosecution. The experience of HSE has been that 'occupational disease reporting levels are extremely low, the information being so incomplete that it is not regarded as an appropriate data set for statistical analysis' [1]. Evidence from the Surveillance of Work-related and Occupational Respiratory Disease (SWORD) [3] and The Health and Occupational Reporting network (THOR) [4] reporting schemes supports this view in relation to respiratory disease and other occupational disease reporting respectively, as does epidemiological study of the population such as the report on hand arm vibration syndrome prevalence in the UK [5].

As a result of this HSE has identified alternative data sources that are preferred for use in describing ill-health, including the Labour Force Survey, THOR, SWORD, EPIDERM—the skin specialist surveillance scheme, Industrial Injury Disablement Benefit (IIDB), death certificates and the use of the attributable fraction (the proportion of the total number of cases of the disease that are caused by occupational exposure from epidemiological studies) [6].

These preferred sources do not provide a complete replacement for the categories of disease currently listed in RIDDOR [2]. As such a patchwork of schemes and data sources are proposed that will have holes rather than overlaps, which is the opposite of what was suggested in 1991 by Carter (at a time when the original RIDDOR Regulations (1985) [7] were known to have a data shortfall when comparing disease reporting to HSE with other sources) [8]. Currently, RIDDOR includes a requirement to report poisonings to a specific range of chemicals, gases and metals. Such information is not included in the information collected by HSE from their preferred sources. New associations between workplace exposures occur and further gaps in understanding the epidemiology of occupational disease will then be apparent. Recently, IARC reclassified formaldehyde as a class 1 carcinogen due to an association with acute myeloid leukaemia [9]. There is no current reporting of this in RIDDOR and none suggested in the preferred sources for ill-health. HSE can expand the preferred sources to fill the gaps that will occur if disease reporting is removed for RIDDOR and include further sources for new associations between exposures and occupational diseases.

The use of electronic medical records in primary care and in other areas of health care may allow for data analysis when occupation is included in such systems, with appropriate safeguards for anonymizing data that is then analysed by a third party. Data linkage with other datasets that include occupation can be considered where the primary electronic record does not have data on occupation [10].

Given the difficulties of disease reporting under RIDDOR the continuing need for infectious disease reporting to HSE seems out of place. The current use of IIDB as a measure of infections underestimates the number of occupational infections. This is because this requires individuals to submit a claim for benefit and to be assessed as eligible for the benefit but most cases do not claim. It is unclear if the infections related to health care and veterinary practice, zoonoses in agriculture and laboratory acquired infections are likely to be reported any better in future under RIDDOR than has occurred in the past 25–30 years.

It may be better for this function to be part of public health services with a requirement on these services to report infection that is work-related to HSE. Systems of notifying infectious disease already exist and could be extended for work-related infections. The recent Legionella outbreak in Edinburgh in 2012 highlights the benefits of public health, HSE and local authority bodies collaborating during an infectious disease outbreak. In addition, health care providers report on incidents of ill-health and could include evidence of staff exposure and
illness in the workplace, together with actions to prevent such occurrences, in such reports. HSE could also access such summary reports for further information on occupational infection risks [11].

We also need a system for HSE to alert physicians to report specific diseases that occur as a result of work to HSE or a designated agency when new diseases are discovered. A system of sentinel health event investigation has been proposed previously [12], which could fill a gap when new diseases emerge that raise a concern of worker exposure. SARS is an example of an infection that had significant impact on health care workers and should be a warning to expect such problems in future [13].

In addition we need to allow physicians to report cases of disease that they suspect may be occupational to HSE or a designated agency so that appropriate investigation and prevention of other cases can occur. Recent evidence of bronchiolitis obliterans from exposure to diacetyl flavouring (‘popcorn workers’ lung’) [14] and progressive inflammatory neuropathy among swine slaughterhouse workers [15] shows that new diseases are still being recognized and HSE should anticipate such issues in future.

Problems of occupational disease reporting are common in other countries and can differ from the UK experience. In other European countries there are different reasons for registries of occupational disease, such as for compensation purposes, statistics and research. There is also evidence of problems of reporting known occupational diseases and concern about inadequate alerting of new occupational diseases [17]. In Canada there is a reliance on data provided by workers’ compensation systems which set definitions for disease compensation which affects the number of cases accepted. In addition, there is a failure to report which may be related to the lack of awareness of the system among patients and specialists such as respiratory physicians [10] and oncologists [17]. Training physicians has been shown to improve reporting behaviours and should be included in post-graduate medical education for general practitioners and other specialists [18].

In summary, it is good that the need for disease reporting through RIDDOR has been reviewed by HSE and alternative sources of data that provide better estimates of disease are used where they exist. It is unclear why HSE wishes to continue to have infectious disease reporting when the evidence shows that the data is incomplete. Alternatives such as those suggested above should be considered. The gaps in reporting that will exist as a result of the changes proposed need to be filled and anticipation of new problems should lead to specific requirements for data collection for investigation, prevention, enforcement and statistical purposes.

Eugene Waclawski
University of Alberta, Edmonton, Canada
e-mail: Eugene.Waclawski@med.ualberta.ca

References