
Exporting occupational disease

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Globalisation has immense ramifications for occupational health, principally the accelerated sharing of occupational risks and consequent injuries and diseases among peoples of different nations. Whether it is the production or people who cross national boundaries, the effect will be the same: the introduction of old and new occupational diseases and injuries to new populations. This is easily asserted, but elusive to study.

Under the best of circumstances, occupational disease is difficult to identify, for all too familiar reasons. Occupationally-induced illnesses such as asthma, emphysema, or cancer usually have multiple causes, and the occupational attribution may be difficult to specify. The decades-long period between exposure to occupational toxins and subsequent chronic occupational illnesses obscures the causal linkage to worker and physician alike. Physicians often have little intrinsic interest and even less incentive to identify causes of illnesses. Even worse, physicians, ever shy about litigation and paperwork, may actively ignore occupational causes of illness.

Set in this context, identifying occupational illnesses among immigrant workers, i.e. – those who have emigrated from their home country to a new host country – is even more difficult. Failure to learn the native language impedes adequate communication about occupational exposures and appropriate navigation of the health care system to the correct doctor. Immigrant workers tend to be less frequently unionised and thereby lack a potential information source and advocate for the recognition of occupational illness. Immigrants are often mobile within the host country, loosening their link to a single employer or industry, which may obscure the occupational roots of their illnesses. Immigrant workers also often work in smaller, decentralized industries, which lack any occupational safety and health infrastructure to address occupational illness and its recognition. Finally, immigrant

workers are vulnerable and frequently fearful, undermining their ability to act, even if they or their physicians suspect that their illnesses may be work-related.

What then happens when immigrant workers return to their home country to retire or to finish their careers? Occupational illness is virtually impossible to document among such workers. Information about workplaces in a different country where the returning immigrant formerly worked is unobtainable, given differences in laws between countries and the lack of intergovernmental cooperation in occupational health and safety. Most returning immigrant workers would presumably scatter to different communities in their home country, making detection of patterns of illness, much less the assembly of a study cohort, unachievable. The lack of a coherent study cohort, combined with low quality or non-existent exposure data, would discourage prospective research scientists who seek methodologic rigor. Finally, the irrelevance of obtaining workers' compensation in a country other than the one where the worker was employed removes an important reason to determine whether an illness is occupational in origin. All of these specific factors, combined with those more general ones cited above, conspire to maintain the invisibility of occupational disease among immigrant workers who return home to live their final years. Given these obstacles, the report in this issue by Merler and colleagues in Italy is quite remarkable (Merler et al. 2003). They document 15 cases of malignant mesothelioma of the pleura and peritoneum among Italians, principally from two different regions of Italy, who had previously worked in a single asbestos cement plant in Switzerland. The authors used a national system of regionalized mesothelioma registries in Italy to identify cases. The only exposure to asbestos that the 15 cases had in common was their work in the implicated Swiss facility, most often beginning three or four decades prior to returning to their homes in Italy and

becoming ill with mesothelioma. Merler and colleagues note that Swiss residents were hardly immune to the disease, since the Swiss canton where the factory was located had the highest rate of pleural cancer in Switzerland. Nonetheless, the full impact of asbestos-related disease caused by the plant would be seriously underestimated unless the burden of mesothelioma identified in Italy were also counted. The documentation of an epidemic of occupational disease among returning emigrants by Merler and colleagues is virtually unique in the literature of occupational disease. Other examples are rare and include, most recently, a study by the same authors of Italian immigrants returning from the crocidolite mines of Wittenoom Gorge, Australia (Merler et al. 1999). The absence of studies is unlikely to be due to a dearth of disease or to the sophistication of the science. Rather, the central problem is piecing together the exposure histories, especially in aggregate, of people with like illness or injuries, who are separated by time and place from their

place in common, a workplace in a foreign country. Mesothelioma is the easiest disease to study among returning emigrants, given its unique relation to asbestos exposure. But, with the increased flow of people and production across national boundaries, the work begun by Merler and colleagues must be extended to other diseases. Only then can the full burden of occupational illness be understood, thereby providing the incentive to prevent some of these most preventable of illnesses, those induced by highly alterable workplace conditions. We especially look forward to continued work in this difficult area by scientists of the European Union, where the unprecedented intergovernmental cooperation and integration of nations may provide the means and stimulate the interest to identify what happens to workers in high-risk occupations when they return to their home countries.

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References

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