I. Legal framework for workers’ compensation

1.1 Laws and regulations

The most important workers’ compensation scheme is administered by the Ministry of Health, Labour and Welfare (MHLW) under the Industrial Accident Compensation Insurance Act (IACIA). The IACIA was enacted in 1947, along with the Labour Standards Act (LSA). The LSA obligates all employers to comply with minimum standards of working conditions specified in this act. The minimum standards of workers’ compensation are presented in Chapter VIII of the act. The purpose of the Industrial Accident Compensation Insurance is to ensure the discharge of the employers’ obligations under the LSA by making employers take out this obligatory insurance.

While the LSA also had a chapter on safety and health, as the contents and relevant regulations and guidelines contained there increased, a separate act was needed and the Industrial Safety and Health Act (ISHA) was drafted and separately enacted in 1972. Article 42 of Chapter V of the LSA designates only “matters concerning the safety and health of workers shall be as provided for in the Industrial Safety and Health Act”; Article 1 of the ISHA also prescribes:

“the purpose of this Act is to secure, in conjunction with the Labour Standards Act, the safety and health of workers in workplaces, as well as to facilitate the establishment of a comfortable working environment, by promoting comprehensive and systematic countermeasures concerning the prevention of industrial accidents, such as taking measures for the establishment of standards for hazard prevention, clarifying the safety and health management responsibility and the promotion of voluntary activities with a view to preventing industrial accidents”.¹

1.2 Businesses and workers covered

The IACIA applies to all private businesses that employ a worker or workers in Japan with very limited exceptions.

National and local government employees (except for part-time local government employees engaged in blue-collar work) are not covered by the IACIA, and other equivalent schemes are set up for those workers. The IACIA does not apply obligatorily to businesses which are categorised as agriculture, forestry, or fishery enterprises with less than five workers; these workers can be covered by the IACIA under special procedures.

Moreover, another special system is established to permit employers of small- and medium-sized businesses, the self-employed who don’t employ workers, and workers assigned to overseas jobs to join the IACIA.

Under the IACIA, all workers are treated without discrimination as to the types of employment, nationality, etc. So a temporary or casual worker, and a migrant worker (also referred to as illegal worker), can receive the equivalent compensation benefits as those of a regular or permanent worker.

Even if a worker suffers from an occupational disease after resignation or retirement from the job in which the worker had been exposed to a hazard, he or she can receive compensation benefits.

Additionally, even if an employer has not paid insurance premiums, a worker can receive compensation benefits, as the government collects insurance premiums for the past period from an employer separately from paying out compensation benefits. Employers are required to pay insurance premiums, which are calculated by multiplying total payable wages by the insurance rate determined for each business category. These rates range from 0.5 percent to 12.9 percent.  

1.3 Summary of the Compensation Act (IACIA)

The purpose of the IACIA which is stated in Article 1 of the act is:

“to grant necessary insurance benefits to workers in order to give them prompt and fair protection against injury, disease,
disability, or death or the like resulting from an employment-related cause or commuting, and to promote the social rehabilitation of workers who have suffered an injury or disease from an employment-related cause or commuting, assist those workers and their surviving family members and secure the safety and health of workers or the like, thereby contribute to the promotion of the welfare of such workers.”

Workers’ accidents are divided into ‘employment accidents’ and ‘commuting accidents’. Commuting accidents have been covered by the act since 1973.

Eight types of insurance benefits are available as follows:

1. **Medical Compensation Benefit**: A victim can get medical treatment without payment in principle until an injury or disease no longer requires treatment.

2. **Temporary Absence Compensation Benefit**: Provided at a rate of 80 percent of the average daily wage starting from the fourth day on which a victim fails to receive wages because of an inability to work due to medical treatment for an injury or disease.

3. **Disability Compensation Benefit**: Payable after an injury or disease no longer requires treatment and the victim remains disabled; payable as a pension or lump sum in accordance with the Disability Grade.\(^3\)

4. **Surviving Family Compensation Benefit**: Payable as a pension or lump sum in accordance with the number, dependency and other factors of surviving family members.\(^4\)

5. **Funeral Expenses**

6. **Injury and Disease Compensation Pension**: Payable (since 1977, partially since 1960) in the case of an injury or disease wherein medical treatment is needed on a long-term or permanent basis, such as for a spinal injury, pneumoconiosis and others; payable as a pension in accordance with the Injury and Disease Grade. A victim can also continue to receive the Medical Compensation Benefit.

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\(^3\) Disability compensation benefit is provided as a pension for a person with a Disability Grade of Class 1-7 and as a lump sum for a case designated Class 8-14.

\(^4\) The surviving family compensation benefit is provided as a pension for family members who were dependent on the victim’s income for their livelihood at the time of death. If there is no such family member, the benefit is provided as a lump sum.
(7) **Nursing Care Compensation Benefit** (since 1996): Awarded to certain recipients of the Disability Compensation Pension or the Injury and Disease Compensation Pension in accordance with the Nursing Care Grade.

(8) **Follow-up Medical Examination Benefit** (since 2001): Provided for a worker who has abnormal findings suggesting cerebrovascular or heart disease in his/her most recent medical examination, conducted under the provision of the Industrial Safety and Health Act.

### 1.4 Procedure for claiming compensation benefits

In order to receive an insurance benefit, a suffering worker (victim) or his/her surviving family must file a claim (submit a designated application form for the compensation) to the relevant Labour Standards Inspection Office (LSIO) each time. There are more than 300 LSIO offices in Japan.

The chief of the LSIO shall decide whether all or part of the compensation benefits should be granted to the worker or his or her surviving family members.

The victim, the surviving family member, the employer, fellow workers, and the victim's doctor may be heard and asked to submit information by the LSIO. Then the LSIO may ask the opinion of medical advisors, and if necessary consult with the Prefectural Labour Office and the MHLW.

Article 23-2 of the Enforcement Regulations of the IACIA states that the employer of a worker can submit an opinion about the claim to the LSIO. This clause was introduced in 1987, following employers’ requests to introduce a system in which an employer can file a claim for re-examination of a decision by the LSIO when an employer is dissatisfied with it.

The deadlines for submitting the application forms are five years for Disability Compensation Benefit, Surviving Family Compensation Benefit and Funeral Expenses and two years for other benefits.

### 1.5 Appeal and litigation

If a victim or surviving family member is dissatisfied with an LSIO decision, he or she can appeal to a Industrial Accident Compensation Insurance Examiner for a re-examination of the decision, and if dissatisfied with this decision, a further appeal can be made to the Labour Insurance Appeal Committee for a third examination.
The examiners are assigned to 47 prefectural Labour bureaus, and the committee is set up at the ministry level. The counsellors, representatives of workers and employers, are assigned to the examiners and the committee, and they can only submit opinions about the claim to the committee.

A victim or dependant dissatisfied with a decision of the committee can bring a case before the court against the chief of the LSIO to revoke the decision.

If the examiner or the committee does not make a decision within three months of an appeal, a victim or dependant can proceed to have the third examination. This rule was introduced in 1996, since previously cases could take 10 years or more to reach a resolution.

1.6 Notification

Article 97 of the Ordinance on Industrial Safety and Health requires that “the employer shall, when a worker was killed or suspended from work due to an industrial accident or injury, suffocation or acute poisoning suffered during employment in work, or within the workplace or buildings attached thereto, submit a report to the chief of the relevant Labour Standards Inspection Office without delay”. But this notification has no links to compensation for workers or dependents.

Also, a doctor who diagnoses an injury or disease which could be of occupational origin is not obliged to notify the fact to the LSIO or other body.

1.7 List of occupational diseases

Tables 1 and 2 of Article 35 of the Ordinance for Enforcement of the Labour Standards Act lists the categories of occupational diseases and injuries recognised under Japanese law.\(^5\) The list was established in 1947 and revised in the current form in 1978:

- No. 1 Diseases resulting from injuries incurred in the course of duty;
- No. 2 Diseases due to physical factors;
- No. 3 Diseases caused by a form of job which involves extreme physical exertion;

\(^5\) For a full list of occupational diseases and injuries covered under the LSA, see Annexure.
No. 4 Diseases due to chemical substances;
No. 5 Pneumoconiosis or diseases due to complication of same;
No. 6 Diseases due to pathogens such as bacteria and viruses;
No. 7 Diseases due to carcinogens, carcinogenic agents, or jobs done in the carcinogenic processes;
No. 8 Brain haemorrhage, subarachnoid haemorrhage, cerebral infarction, hypertensive encephalopathy, myocardial infarction, angina, cardiac arrest including cardiac sudden death, dissecting aortic aneurysm or their attendant disease due to long-term prolonged job or others which significantly aggravate vascular and other lesions (added in 2010);
No. 9 Mental or behavioural disorders or their attendant disease due to jobs associating human, life-threatening accidents or incidents which impose excessive psychological loads (added in 2010);
No. 10 In addition to the disease listed in the preceding items those designated by the Minister of Health, Labour and Welfare;
No. 11 Other diseases which clearly result from work activities.

In the list above, categories No. 2, 3, 4, 6 and 7 all have sub-categories detailing those occupational injuries and diseases falling in each category. These sub-categories are referred to as “Specifically Enumerated (Listed) Provisions”. In Japan an ‘open system’ is adopted: Category ‘No. 11 Other diseases’ is known as the “Comprehensive Relief Provisions” (CRP). Thus, even if a disease or injury is not included in any “Specifically Enumerated (Listed) Provision”, such a disease can be recognised as an occupational disease under the ‘Comprehensive Relief Provisions’.

II Statistics and realities

2.1 Occupational deaths and injuries

The numbers of businesses and workers covered by the IACIA has increased. At present the number of businesses covered by the IACIA is approximately 2.6 million and the number of workers covered is approximately 52.8 million (Fig.1).
Although workplace accidents have decreased over the long term, there are still a considerable number of cases annually. We can identify three phases:

Phase 1: 1960-70 Peak period of workplace accidents and diseases
Phase 2: 1970-80 Halving of incidence rate
Phase 3: 1980-present Stabilisation or modest decrease in incidence

The statistics for deaths are more likely to reflect the real situation, because it is relatively difficult to conceal. Japan succeeded in halving the number of fatal accidents in only 10 years (1970-80), i.e., in the period following the enactment of the Industrial Safety and Health Act in 1972. Following that big, initial success, the number of workplace deaths, injury and disease has remained unchanged and the improvements may even have reversed.

The numbers of casualties (deaths, injuries, and diseases) and new receivers of the compensation benefit under the IACIA shows similar trends. It should be noted here, that concerning injuries and diseases, only cases requiring an absence of eight days or more were included in the statistics until 1972, after which they expanded the cases to those requiring only an absence of four days or more.

In a case of an occupational injury, key points for the investigations by the LSIO are whether a worker had an accident or not, and whether the accident caused such injury. It seems that there is relatively less trouble in cases of injury than those of disease. But in
fact, there are incidents that are referred to as the ‘hiding of accidents’, i.e., unreported accidents in which a worker or workers are injured.

Article 23 of the Enforcement Regulations of the IACIA states “the employer shall promptly provide and certify the necessary information when a victim or his/her surviving family asks.” But this clause is not subject to punishment. In fact, employers often refuse the certification and other assistance.

If the total number of occupational deaths and injuries is indexed, such that the total number of deaths is considered as one, then the index for injuries requiring an absence of four days or more would fall between 81-105 and the index for injuries requiring an absence of three days or less would range between 330-399 for the years 2006-2010. (See Table 1 below.) But looking into this by industry, it can be seen that there are substantial differences between industries. An analysis of these numbers will be useful in order to eliminate the ‘hiding of accidents’.

### Table 1 Comparison of Severity of Occupational accidents

<table>
<thead>
<tr>
<th>Year</th>
<th>Industry</th>
<th>New Receivers</th>
<th>Deaths</th>
<th>Absence of 4 days or more</th>
<th>Absence of 3 days or less</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
<td>Index</td>
</tr>
<tr>
<td>2006</td>
<td>Total</td>
<td>606,645</td>
<td>1,472</td>
<td>119,906</td>
<td>81.5</td>
</tr>
<tr>
<td>2007</td>
<td>Total</td>
<td>607,348</td>
<td>1,357</td>
<td>119,999</td>
<td>88.4</td>
</tr>
<tr>
<td>2008</td>
<td>Total</td>
<td>604,139</td>
<td>1,268</td>
<td>118,023</td>
<td>93.1</td>
</tr>
<tr>
<td>2009</td>
<td>Total</td>
<td>534,623</td>
<td>1,075</td>
<td>104,643</td>
<td>97.3</td>
</tr>
<tr>
<td>2010</td>
<td>Total</td>
<td>574,958</td>
<td>1,195</td>
<td>106,564</td>
<td>89.2</td>
</tr>
<tr>
<td>2010</td>
<td>Manufacturing</td>
<td>138,463</td>
<td>211</td>
<td>22,817</td>
<td>108.1</td>
</tr>
<tr>
<td>2010</td>
<td>Mining</td>
<td>712</td>
<td>5</td>
<td>317</td>
<td>63.4</td>
</tr>
<tr>
<td>2010</td>
<td>Construction</td>
<td>53,217</td>
<td>365</td>
<td>21,033</td>
<td>57.6</td>
</tr>
<tr>
<td>2010</td>
<td>Transportation</td>
<td>39,797</td>
<td>181</td>
<td>15,087</td>
<td>83.4</td>
</tr>
<tr>
<td>2010</td>
<td>Forestry</td>
<td>3,822</td>
<td>59</td>
<td>2,090</td>
<td>35.4</td>
</tr>
<tr>
<td>2010</td>
<td>Other</td>
<td>338,947</td>
<td>374</td>
<td>45,220</td>
<td>120.9</td>
</tr>
</tbody>
</table>

### Figure 2 Occupational Deaths, Injuries and Diseases

- **New Receivers**: ISHA 1972
- **Deaths**: Casualties (deaths and injuries requiring an absence for 4 days (8 days = before 1972) or more)
- **Diseases**: Number of new receivers and casualties (*1,000)**

The numbers of casualties (deaths, injuries, and diseases) and new receivers of the compensation benefit under the IACIA shows similar trends. It should be noted here, that concerning injuries and diseases, only cases requiring an absence of eight days or more are included in the statistics until 1972, after which they expanded the cases to those requiring only an absence of four days or more. If the total number of occupational deaths and injuries is indexed, such that the total number of deaths is considered as one, then the index for injuries requiring an absence of four days or more would fall between 81-105 and the index for injuries requiring an absence of three days or less would range between 330-399 for the years 2006-2010. (See Table 1 below.) But looking into this by industry, it can be seen that there are substantial differences between industries. An analysis of these numbers will be useful in order to eliminate the ‘hiding of accidents’.
2.2 Occupational diseases

The number of victims of occupational diseases compensated by the IACIA is not decreasing. (See Figure 2 above.)

Category No.1, diseases resulting from injuries are called “accident disease” and accounts for about half of the total occupational disease cases receiving compensation. Recognition of such disease is relatively easy as is an injury case.

Categories No.2-11 are “non-accidental diseases” or “occupational diseases in a limited sense”.

With no contradictory evidence and if all the requirements below are satisfied, a disease listed in the Specifically Enumerated (Listed) Provision is considered an occupational disease:

1. A hazard prescribed (i.e. stated) in the list of occupational disease exists in the workplace.

2. The condition of exposure to such hazard is recognised as enough to cause a prescribed disease in terms of dose, period, and form of exposure.

3. The appearance and progress of such disease is consistent with medical knowledge on health due to such a hazard.

For recognition of a CRP disease, the causal relationship between a disease and workplace must be proved on a case-by-case basis. Recognition criteria have been set up for approximately 30 diseases in administrative notices by the chief of Labour Standards Department of the MHLW, whereby if a disease satisfies the relevant recognition criteria, it should be recognised as an occupational disease.
But in all cases a victim or his or her surviving family members shoulder the burden of proof.

As regards the recent trend of major occupational diseases, pneumoconiosis and complications of this disease (Category No.5) and vibration disease (No.3-3), these have been traditionally the two major diseases and they have been decreasing. (See Figure 3 above) Since 2003, primary lung cancer, complicated by pneumoconiosis, has been dealt with as a disease in a Specifically Enumerated (Listed) Provision.

Musculoskeletal disorders (upper limb disorder: No.3-4, low back pain: No.3-2), asbestos-related (AR) cancer (No.7-7), brain/heart disease and mental disorders are attracting attention from society. Brain/heart disease and mental disorders, including cases of suicide such as karoshi, i.e., death due to overwork and karojisatsu, i.e., suicide due to overwork, have been dealt with as CRP diseases and new categories for them (No.8 and 9) were introduced in 2010.

After a big asbestos scandal in 2005, many people became aware of asbestos-related diseases. Surviving family members of the victims who died within the past five years applied for compensation benefits from the IACIA. This is one reason why the number of reported asbestos-related cancers cases jumped in 2006.

The year of the establishment and revisions of the recognition criteria for some major occupational diseases are as follows:

- Mental disorders – 1999 and 2011
- low back pain – 1968 and 1976
Data on the number of applications and of uncompensated cases are available for only a few diseases, and data on the numbers by sex, age, job, length of medical treatment/absence, amount of payments, etc. are almost unavailable. (See Figure 4 above.)

III. Barriers and challenges in seeking compensation

3.1 Case Studies

Case 1 – Seeking fair compensation for all asbestos victims

A big asbestos scandal, the “Kubota Shock”, erupted in the summer of 2005. It was revealed that not only many (former) workers of the then defunct Kanzaki plant of Kubota in Amagasaki City had died of asbestos-related diseases, but there were mesothelioma victims among residents who lived near the plant and had no history of exposure to asbestos through their own occupations. With awareness of the disease aroused, more and more occupational and non-occupational asbestos victims were detected and reported throughout the country.

The Act of Asbestos Health Damage Relief was enacted and came into force in 2006, providing compensation for all asbestos victims without exception.

This act set up two relief schemes. The first was the relief scheme for non-employee asbestos victims who were not covered by the IACIA. This is administered by the Ministry of the Environment and financed by central and local governments and all employers. As a matter of practice the benefit paid by this scheme is a total three million yen (about US$30,000) to each victim, and it is extremely low in comparison to the benefit paid by the IACIA, which is usually paid in pension form to surviving family members.

As a result of Kubota Shock, many Japanese became aware of asbestos-related diseases. But if a victim, who was a worker, died of asbestos-related disease more than five years ago, his/her surviving family members were ineligible to apply for compensation from the IACIA, because of the “statute of limitations” which had already expired. However, since there were so many such cases, a second, separate scheme was devised to give relief in those cases. This is administered by the Ministry of Health, Labour and Welfare and financed by the Industrial Accident Compensation Insurance. The benefit is almost equal to the compensation awarded by the IACIA.
Regarding cases of mesothelioma, if the diagnosis was confirmed, the victim or surviving family members can receive compensation from the IACIA or under one of new relief schemes and this means all mesothelioma cases will receive some compensation.

Usually data on compensation is shown by the year in which compensation was paid. (See Figure 5 below). However, JOSHRC has demanded the government additionally disclose the data according to the year of the death of the victim in order to verify the actual situation. As of 31 March 2010, 57.3 percent of all mesothelioma deaths between 1995 and 2010 have been compensated by the various schemes. The compensation ratio varied from 23.0 percent in 1995 to 90.1 percent in 2005, the year of the Kubota Shock. It is expected that cases eligible for benefits under the IACIA or a relief scheme for those cases where the “statute of limitation” had been in effect would be covered by new relief schemes for non-employee cases.

Regarding asbestos-related lung cancers, more complicated proof is required and the situation as regards compensation is poor. JOSHRC has not been satisfied with the current situation and have called for fair and equal compensation for all asbestos victims and their families.

At the same time, JOSHRC has succeeded in making the ministry disclose the names of companies where asbestos-related diseases were recognised as occupational diseases every year.

One of the reason why JOSHRC and others succeeded in getting those relief schemes was that the occupational victims and environment victims was not divided but united together, built a coalition with other social groups, attracted the attention of the media and civil society concern groups and shaped public opinion.

On the other hand the differences between the workers’ compensation and relief given to environment victims has made all reconsider various aspects of compensation and how to achieve fair and equal compensation for all and/or to improve the current schemes, not only for asbestos victims but for all victims of occupational diseases.

Considering only cases of compensation for victims of asbestos, so far only six countries – France, Japan, the Netherlands, Belgium, the UK and Korea – have introduced relief schemes for non-employee asbestos victims or universal compensation schemes for all asbestos victims. While we know there is no one-size-fits-all, still we have many common challenges we can tackle together.
Case 2: International first - Bile duct cancer among printing workers uncovered

As of the end of 2012, a new occupational disease was uncovered, when 17 active and former workers of a proof-printing plant, SANYO-CYP Co., Ltd, in Osaka were found to be suffering from bile duct cancer which is in fact a very rare cancer. However, by 2011, seven former workers of this plant had died. (See Table 2 below.)

Proof-printing is a kind of test printing to ensure the printing quality and the plant prints small numbers of sample sheets for review before the customer orders thousands of sheets from other ordinary printing companies. The workers need to clean the rollers and the machine’s blankets frequently, between an estimated 300 to 800 times per day in each plant. The printing room was in the basement with no windows and very bad ventilation. The plant was operated around the clock with a two-shift system. In addition, the workers were not provided with adequate protective masks.

In March 2011, Kansai OSH Centre (KOSHC), an affiliate of JOSHRC, heard this story from a friend of one of the victims, here named Victim H. She had already obtained certain information on nine victims. Knowing that the number of workers in the proof printing room was regulatory only around 30, the incidence of cancer in workers there was unusually high. But there had been no such cases recognized as occupational disease not only in Japan but anywhere in the world. Furthermore in some cases the statute of limitation for workers’ compensation had already expired.
KOSHC tried to reach out to all the victims and their families, and encouraged them to unite. The centre also asked two university professors of epidemiology to carry out a scientific study using all available information. The study analysing five bile duct cancer cases (Victims C, D, F, H and I) was presented at an annual meeting of the Japan Society for Occupational Health in May 2012 and concluded that those cancers should be attributed to chemical exposure at the workplace and that the suspected causal agent would be 1, 2-dichloropropane and dibromopropane contained in the machine cleaning agents. At the same time the victims and their families made applications for workers’ compensation/insurance benefits using the written opinion of those professors.

The media covered this story extensively. Then, the Ministry of Health, Labour and Welfare (MHLW) conducted an inspection of the plant and surveyed 18,000 printing plants throughout Japan to ensure compliance with the relevant laws and regulations, ordered printing and other industries to review and improve their workplace conditions, issued precautionary notices, and offered telephone consultation service for workers. As of March 2013, a total of 46 bile duct cancer cases had been found among printing workers in addition to the SANYO-CYP cases, and applications for workers compensation insurance benefits had been filed.

In addition, the ministry set up two investigation teams and commissioned scientific researchers to them: The first team is seeking information to make an immediate decision on workers’ compensation and the second team is conducting a more comprehensive epidemiological study. The former presented its report to the ministry and acknowledged that all the SANYO-CYP cases were the result of occupational diseases as of March 2013 and will further set up recognition criteria for other bile duct cancer cases. The second team aims to finalize its research at the end of 2014.

KOSHC and JOSHRC are calling for compensation for all victims and improvements in the recognition of occupational cancers, as well as the notification system and preventive measures. The centres have also circulated the information to international colleagues. In Korea the Wonjin Institute for Occupational and Environmental Health in cooperation with unions of printing and shoemaking workers is carrying out relevant surveys. We will have a joint meeting in Seoul in July 2013.
Table 2  Bile duct cancer victims of the SANYO-CYP Co., LTd.

<table>
<thead>
<tr>
<th>Victim</th>
<th>Sex</th>
<th>Year of Birth</th>
<th>Work Period</th>
<th>Year of Diagnosis</th>
<th>Year of Death (Age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>Male</td>
<td>1978</td>
<td>1997-2012</td>
<td>2010</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Male</td>
<td>1970</td>
<td>1999-</td>
<td>2010</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Male</td>
<td>1974</td>
<td>1993-</td>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Male</td>
<td>1973</td>
<td>1999-</td>
<td>2012</td>
<td></td>
</tr>
</tbody>
</table>
Annexure

List of occupational injuries and diseases as found in the Ordinance for Enforcement of the Labour Standards Act

Table 1-2. (Re: Art. 35)

1 Disease resulting from injuries incurred in the course of duty

2 The following diseases due to physical factors:
2-1 Disease in the anterior part of the eye or of the skin due to work exposed to ultraviolet rays
2-2 Eye disease such as retinal burns and cataract or skin disease due to work exposed to infrared rays
2-3 Eye disease such as retinal burns or skin disease due to work exposed to laser beams
2-4 Eye disease such as cataract due to work exposed to microwaves
2-5 The following disease due to work exposed to ionizing radiation: radio dermatitis such as acute radiation disease and ulceration, eye disease due to radiation such as cataract, radiation fibrosis of the lung, troubles of the blood dyscrasia such as aplastic anemia, bone necrosis, and other disease due to radiation
2-6 Caisson disease or diver’s disease due to operations in high-pressure rooms or diving
2-7 Mountain sickness or aircraft dysbarism due to work done in low-pressure places
2-8 Heat stroke due to work done in hot places
2-9 Burns due to jobs to handle extremely heated materials
2-10 Frostbite due to jobs done in cold places or to handle cold materials
2-11 Hearing disability such as deafness due to jobs done in noisy places
2-12 Necrosis such as of finger tissues due to jobs exposed to supersonic waves
2-13 In addition to the disease prescribed in 2-1 to 2-12 inclusive their annexed disease and other disease which clearly result from jobs exposed to physical factors

3 The following diseases caused by a form of job which involves extreme physical tension:
3-1 Muscle, tendon, bone, or joint disease or prolapse of internal organs due to strenuous jobs
3-2 Low back pain due to jobs to handle heavy objects, those done in unnatural postures or others which involve excessive tension to low back

3-3 Peripheral circulatory failure, peripheral nerve disorder, or motive organ disorder of fingers or forearm etc. due to jobs which vibrates the body due to use of equipment or machinery such as rock drills, rivetters, or chain saws

3-4 Motive organ disorder of back of head, neck, shoulder girdle, upper arm, forearm or fingers due to jobs of repeatedly entering data to electric computers or others which involve excessive tension to the upper limbs

3-5 In addition to the diseases listed in 3-1 to 3-4 inclusive their annexed disease and other disease which clearly result from jobs executed in ways which involve excessive tension to the body

4 The following diseases due to chemical substances etc.:

4-1 Disease designated by the Minister of Health, Labour and Welfare due to jobs exposed to simple chemical substances or compounds (including alloys) designated by the Minister of Health, Labour and Welfare [151 items]

4-2 Inflammation of mucous membranes of the eyes or respiratory troubles such as inflammation of mucous membranes of the respiratory organs due to jobs exposed to pyrolytic products of synthetic resins such as of fluoric resin, vinyl chloride resin, or acrylic resin

4-3 Skin disease due to jobs exposed to resin hardeners manufactured from soot, mineral oil, lacquer, tar, cement, or amine or some other equivalent

4-4 Skin disease, conjunctivitis or respiratory Disease such as rhinitis or asthma bronchiale due to jobs exposed to proteolytic enzymes

4-5 Respiratory disease such as allergic rhinitis or asthma bronchiale due to jobs done in places where particulate of lumber or fur or some other equivalent are scattered or those exposed to antibiotics or some other equivalent

4-6 Respiratory disease due to jobs done in places where particulate of cotton waste or some other equivalent are scattered

4-7 Benign asbestos pleural effusion and diffuse pleural thickenings due to jobs exposed to asbestos

4-8 Hypoxia due to jobs done in places with low oxygen content

4-9 In addition to the diseases listed in 4-1 to 4-8 inclusive, their annexed disease and other disease which clearly result from jobs exposed to chemical substances
5 Pneumoconiosis or diseases listed in the items of Article 1 of
the Ordinance for Enforcement of the Pneumoconiosis Act
(Ordinance No. 6 of the Ministry of, Labor 1960) which
are complications of pneumoconiosis prescribed by the
Pneumoconiosis Act (Act No. 30, 1960) due to jobs done in
places where particulate is scattered. [pulmonary tuberculosis,
tuberculous pleuritis, secondary bronchitis, secondary
bronchiectasis, secondary pneumothorax, primary lung cancer]

6 The following diseases due to pathogens such as bacteria and
viruses:
6-1 Infectious diseases due to treating, nursing or caring patients or
jobs to handle pathogens for research and other purposes
6-2 Infectious diseases such as brucellosis and anthrax due to jobs
to handle animals and their carcasses, fur, hide, other animal
materials, or rags and other old cloth
6-3 Leptospirosis such as Weil disease due to jobs in damp places
6-4 Tsutsugamushi disease due to outdoor jobs
6-5 In addition to the diseases listed in 6-1 to 6-4 inclusive their
annexed disease and others which clearly result from jobs exposed
to pathogens such as bacteria and viruses

7 The following diseases due to carcinogen, carcinogenic agent, or
jobs done in the carcinogenic processes:
7-1 Tumor of urinary tract due to jobs exposed to benzidine
7-2 Tumor of urinary tract due to jobs exposed to betanaphthylamine
7-3 Tumor of urinary tract due to jobs exposed to 4-aminodiphenyl
7-4 Tumor of urinary tract due to jobs exposed to 4-nitrodiphenyl
7-5 Lung cancer due to jobs exposed to his (chloromethyl) ether
7-6 Lung cancer due to jobs exposed to benzotrichloride
7-7 Lung cancer or methotelioma due to jobs exposed to asbestos
7-8 Leukemia due to jobs exposed to benzene
7-9 Angiosarcoma of liver or hepatocellular carcinoma due to jobs
exposed to vinyl chloride
7-10 Leukemia, lung cancer, skin cancer, osteosarcoma, thyroid
carcinoma, multiple myeloma or nonhodgkin lymphoma due to
jobs exposed to ionizing radiation
7-11 Tumors of urinary tract due to jobs the auramine manufacturing
process
7-12 Tumors of urinary tract due to jobs in the magenta
manufacturing process
7-13 Lung cancer due to jobs in the coke or producer gas manufacturing process
7-14 Lung cancer or cancer in the upper respiratory organs due to jobs in the chromate or bichromate manufacturing process
7-15 Lung cancer or cancer in the upper respiratory organs due to jobs in the nickel smelting or refining process
7-16 Lung or skin cancer due to jobs in the processes to manufacture or refine metals using ores containing arsenic or those in inorganic arsenic compounds in manufacturing process
7-17 Skin cancer due to jobs exposed to soot, mineral oil, tar, pitch, asphalt, or paraffin
7-18 In addition to the diseases listed in (a) to (q) inclusive their annexed disease and others which clearly result from jobs exposed to carcinogen, carcinogenic agent, or jobs done in the carcinogenic processes

8 Brain haemorrhage, subarachnoid haemorrhage, cerebral infarction, hypertensive encephalopathy, myocardial infarction, angina, cardiac arrest including cardiac sudden death, dissecting aortic aneurism or their attendant disease due to long term prolonged job or others which significantly aggravate vascular and other lesions

9 Mental or behavioural disorders or their attendant diseases due to jobs associating human life-threatening accidents or incidents which psychologically impose excessive loads

10 In addition to the diseases listed in the preceding items those designated by the Minister of Health, Labour and Welfare.

11 Other diseases which clearly result from work-related operations