# Women and occupational diseases. The case of Belgium

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**Report 122**

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# Foreword

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Compensation for occupational diseases plays a key role. At an individual level, it represents support by the social security system to ensure occupational disease sufferers of a certain level of income. On a collective level, it gives special visibility to particular occupational health problems, thereby helping to build awareness among all those concerned with prevention policies.

In Belgium, as in most industrialized countries, the compensation system was established in stages. The first piece of legislation dates back to 1927. Although the system has developed considerably in just over 80 years, no comprehensive study has ever been done of the respective situations of women and men

This report is a cooperative venture by Belgium's Council for the Equality of Women and Men and the European Trade Union Institute. It is an initial stocktaking based mainly on the Occupational Diseases Fund (FMP) statistics and the findings of surveys into working conditions in Belgium or, where there was no data, in neighbouring countries.

For the Council for the Equality of Women and Men, it was important to do a critical analysis of the statistical data to identify specific problems potentially related to gender differential treatment, as called for in a Council opinion adopted on 26 June 2001 on the gender and health impacts of working conditions.

For the European Trade Union Institute, the research contained in this report forms part of a set of activities intended to strengthen the link between occupational health policies and equality policies.

Both organizations believe that these issues need to be debated both in Belgium and in the European Union. Hopefully, this will help to raise awareness amongst the many stakeholders involved in establishing, recognising, compensating and preventing work-induced illnesses.

# Introduction

The international literature on public health points up the scant attention paid to diseases caused by poor working conditions and a lack of prevention in workplaces[1]. Most of such health damage is disregarded by most occupational disease reporting and compensation systems.

Since the 1980s, various authors have described these systems as operating like a set of filters[2] which may be of different kinds: definitional (as to what counts as a work-related disease), institutional, legislative, social or cultural.

The combined effect of these filters is not just quantitative, limited to generally under-rating the harm that working conditions and jobs do to health. There are also important qualitative effects. Information produces biases. The available data do not paint a scaled-down picture of the bigger reality. They are also highly selective. Some diseases are nigh-invisible compared to others: this is particularly true of cancer and mental health problems. Some categories of worker are also more affected by ignoring the link between work and health: contingent workers, migrant workers, etc. For the past twenty years, different authors have been pointing out how gender permeates the filtering of work-related illnesses[3].

This situation is partly to blame for a vicious circle: there is less prevention in women-dominated sectors, which results in less attention paid to the appearance of work-related health problems and reinforces stereotypes about women's work being less hazardous to health.

This report sets out to be an exploratory study. It examines and analyzes the available data, focusing on two main sources: the statistics of Belgium's Occupational Diseases Fund (FMP), and the data on working conditions in Belgium from the European Working Conditions Survey done by the European Foundation for the Improvement of Living and Working (called the Dublin Foundation throughout).

It also presents data from other EU countries to supplement the limited data from sources available in Belgium. There are two reasons for using non-Belgian

**1.** One pioneering study of the United States was that of Landrigan and Markowitz (1989).
**2.** See, e.g., Webb *et al.* (1989); Azaroff *et al.* (2002).
**3.** See, e.g., Dembe (1996), Messing (2000), Vogel (2003), Probst (2009), Tiev (2011).

statistical sources. One is that it enables a comparative analysis. The other is that where there are no Belgian data, other sources help to formulate issues. This is based on the premise that, despite real differences in working conditions and the practicalities of occupational segregation, data from other European countries enable issues relevant to Belgium to be framed.

This report contains the following sections:
— Section 1 succinctly reviews the legal framework for the recognition and prevention of occupational diseases in Belgium. It does not profess to be a detailed, original analysis. It aims only to give landmark developments that will facilitate understanding of the following sections of the report;
— Section 2 summarizes what I considered to be the most relevant Occupational Diseases Fund statistics for a gender analysis;
— Section 3 offers the bases for an assessment of the discrepancy between the recognition and compensation of occupational diseases for women and the state of their occupational health. It draws mainly on statistical data from the European Working Conditions Survey done by the Dublin Foundation supplemented with selected data from neighbouring countries;
— Section 4 makes recommendations for further research on the gender analysis of the impact of health on women's work in Belgium;
— Section 5 makes policy recommendations.

Some of the Sections 4 and 5 proposals are included in more detail as datasheets in Annex 3 to facilitate discussion by the institutions concerned.

Thanks are owed to:

— Marianne De Troyer (ETUI) for her input to the final version of the report and writing the Annex 3 datasheets;
— Anne Kirsch and Karim Wilmotte of the Occupational Diseases Fund for kindly answering my questions and providing me with various statistics;
— Daniela Tieves, who ran a European Trade Union Institute research project on women and occupational diseases in different European countries.

# Section 1
# The legal and institutional framework of reporting, recognition and prevention of occupational diseases in Belgium

The purpose of this section is simply to give the landmark developments that will make the contents of the report easier to understand.

## The 19th century: from no statutory provision to protective exclusion of women and children

The harm work does to health was recognized as a big problem from the early days of the industrial revolution. The intensive exploitation of the first generations of industrial workers took a devastating toll of human health. Nineteenth century accounts, investigations and evidence paint a consistent picture of industrial workers as creatures recognizable on sight by the havoc wrought to their bodies by work. Sallow complexions, undersize children, breathing difficulties experienced by miners and other workers exposed to respiratory hazards, large numbers of mutilations, etc. Employment relations left their mark on bodies as a biological fact. The situation of women has been extensively chronicled in the 19thC investigations into working conditions, although some occupations have been largely overlooked: much more detailed data are available for women labourers than for domestic servants. In Belgium, Interior Minister Jean-Baptiste Nothomb had a Commission set up in 1843 headed by Edward Ducpétiaux, inspector general of prisons and charitable institutions, to carry out a major survey on the "conditions of the labouring classes and child labour". Its findings were published in 1846 and 1848. The Commission crafted draft legislation on the inspection of workshops, mills and factories, and on child labour. The bill had 25 sections, one of which limited the actual daily working time of adults to 12 ½ hours. It also proposed prohibiting industrial employment for children under the age of ten, limiting young people aged 10-14 to working no more than 6 ½ hours a day, and young workers aged 14-18 to no more than 10 ½ hours.

The 1843 Commission's proposals never became law. Every one of the few government bills on the work of women and children was thrown out by Parliament. The issue of women's labour was the subject of searing reports written by various committees who failed to sway the legislature's resolve not to intervene in employment matters.

Belgium was the last western European country to introduce specific legislation on working conditions. Before the 1886 workers' revolt, the legal rules were chiefly administrative regulations intended to enforce labour discipline

and punish forms of collective action by the labour movement (employment certificate, outlawing sturdy begging, making combinations illegal, etc.). The coercive apparatus of the state was put to work for the formation of a wage labour market. Between 1831 and 1887, every attempt to regulate, even if only child labour, was opposed by both Catholic and laissez-faire circles, while most other European countries had already passed legislation on these matters.

After the 1886 workers' revolt[4], legislation was brought in which combined punitive provisions on striking with the early makings of labour law.

One of the cornerstones of this first legislative milestone was the Child and Women's Labour Act of 31 December 1889. The general approach of this legislation is akin to that taken at the time by all industrialized countries. Women were placed under the "wardship" of lawmakers and excluded from a number of work situations. It is an approach that combined protection and discrimination but did not see the prevention of poor working conditions as a priority. The 1889 Act prohibits industrial work by all children under twelve, and limits the daily working time to twelve hours (with at least an hour and a half rest) for boys aged 12 to 16 and girls aged 12 to 21. It prohibits women under 21 from underground work in mines, and also makes it unlawful to employ women in the four weeks following childbirth, but the lack of a wage guarantee severely penalized women wishing to enforce that right.

Another practical outcome of the 1889 Act was the creation in 1891 of a corps of labour inspectors, merged with the classified facilities inspectorate in 1894.

## The 20th century: a gradually asserted right couched in gender neutral terms

Retracing the development of the legislative framework on prevention is beyond the scope of this study. In gender equality terms, it evolved from a set of rules that treated women as a specific category in an approach that combined protection and discrimination with rules formulated in gender neutral terms that effectively disregarded the interactions between gender inequality and health. The only rules specific to women's situation related to motherhood (childbirth, breastfeeding).

The legislative framework on prevention has evolved considerably since 1889. It established specific institutions and bodies like prevention and protection at work committees (formerly, health and safety committees) and preventive services. A wide gap existed between this legislative framework and the aim of equality between men and women. The linkage between the right to equality

4. A workers' uprising which broke out in Liege in March 1886 spread to all industrial areas and turned into a riot in Charleroi. Looting and pillaging were harshly repressed (14 killed and many injured). This movement born of despair and the fear it engendered triggered a spate of political and employment reforms.

and that of staying healthy at work was all-but non-existent. A huge potential went ignored. Including it would arguably have added greatly to the effectiveness of the legal provision on both equality and health.

The use of gender-neutral language is wholly consistent with indirect discrimination. The most obvious example is the exclusion of "domestic workers" (mostly female) from the scope of the Wellbeing at Work Act (1996) and its implementing regulations. Likewise, the lack of specific rules on the prevention of reproductive risks can result in indirect discrimination. Employers may find it more advantageous to employ male staff than to prevent such risks insofar as specific obligations arise only when workers are pregnant.

The system for compensating work-related hazards was put in place in stages in a way akin to those of other Western European countries, starting with the passing of the first Work Accidents Act (Act of 24 December 1903). It was expanded after the First World War to include a very small number of occupational diseases (Act of 24 July 1927). Compensation of work accidents is organized through a private insurance system regimented by the Work Accident Fund, while compensation for occupational diseases is part of a specific branch of social security, the central institution of the system being the Occupational Diseases Fund (FMP) whose tasks range from compensation to prevention but also include information, research and education. The trade unions and employers' associations are represented in the FMP's management bodies.

One peculiarity of the Belgian legal system is to grant employers almost complete immunity from liability where the cause of occupational accidents and diseases is a lack of prevention[5]. This is compounded by the poor rate of criminal prosecutions. Except in cases of serious and fatal accidents, employers who have failed in their prevention obligations are almost never prosecuted. The practical impossibility of attaching civil liability to an employer – even one who has been grossly negligent in prevention - was one of the things that prompted lawmakers to create the Asbestos Fund (AFA ) by the Act of 27 December 2006.

Regrettably, the creation of a specific fund for some asbestos-related diseases[6] was not accompanied by a broader debate on the state of the law and the fact that the rules of civil liability are now an obstacle to prevention.

**5.** The Asbestos Fund further extends the immunity enjoyed by firms that have exposed people other than their employees to asbestos. To be compensated out of the Asbestos Fund, victims must waive their claim to damages on the basis of ordinary law liability. This provision has arguably allowed companies like Eternit to make significant savings: its contribution to the Asbestos Fund is less than the compensation scheme it had previously set up (Molitor, 2010).

**6.** The most common disease linked to exposure to asbestos - lung cancer - is not compensated by the Asbestos Fund.

## Today: the key players and other stakeholders in prevention

There are two circles of stakeholders. **In workplaces**, the Wellbeing at Work Act lays down clear rules on the prevention obligations of employers, workers, their representatives (especially, the role of Prevention And Protection At Work Committees, CPPTs[7]) and internal and external preventive services.

The rules on concurrent activity and outsourcing situations are less systematized and generally refer only to subcontracting situations where an outside firm (or independent contractors) work in another company's workplace. The chances are that stricter enforcement of the existing rules would improve prevention in systematically outsourced work like cleaning[8].

**Outside workplaces**, the reform started in 1996[9] has made no very significant changes. A set of essential functions are performed by public authorities (Labour Inspection, federal work and employment department, justice administration institutions, etc.) in a wide range of areas: regulation, inspection, enforcement, dissemination of workplace-derived data, research, information, etc. Unlike most European countries and the rest of the world, Belgium has no public agency in charge of researching into occupational health. Broadly-speaking, most of the information available comes from the work-related risks compensation schemes, which greatly limits knowledge generation and priority-setting for prevention policies.

Inspection is one of the weakest links in prevention provision. The health and safety inspectorate is staffed by fewer than 200 inspectors. In 2009, each inspector had an average of 1 877 workplaces with a total of more than 26,000 workers to inspect[10]. The International Labour Organization's recommended ratio for industrialized countries is at least one inspector for every 10,000 workers.

A national wellbeing at work strategy adopted for 2008-2012 contains no gender analysis of the situation, and sets no specific objectives linking occupational health to equality policies.

In addition to its core remit over compensation for occupational diseases, the Occupational Diseases Fund (FMP) also has responsibilities for prevention. In practice, these are carried out mainly in three areas: preventive transfers

**7.** In Belgium, companies with at least 50 employees must have such a committee which is formed of equal numbers of the employer's representatives and employee representatives elected from lists put up by the trade unions.

**8.** On working conditions in the cleaning industry and their impact on health, see *HesaMag* No. 2, 2nd semester 2010.

**9.** EU directives resulted in the legislative framework for occupational health being reformed in the 1990s. The centrepiece of this reform is the Wellbeing at Work Act of 4 August 1996.

**10.** *Rapport annuel 2009 de la Direction générale du contrôle du bien-être au travail*, octobre 2010 (health and safety inspectorate's 2009 annual report).

of pregnant workers[11], hepatitis prevention (limited here to vaccinations) and prevention of back injuries. The FMP is the successor to a private insurance system introduced in 1927 and renewed in the aftermath of World War II when the social security system was established. Insurance companies did not want to lose the lucrative occupational risks insurance market. In 1963, as a result of the recognition of silicosis as an occupational disease, the social security system took over insurance against occupational diseases, leaving the more profitable occupational accidents branch in the hands of private insurers.

There is real involvement by the joint industrial relations system (National Labour Council[12], joint industrial committees, trade union and employer association members of many official bodies) notwithstanding that questions may be asked about the overall consistency of its action.

Involvement by the public health stakeholders is very limited, much as if occupational health were cut off from the outside world, governed by specific rules and the preserve of specific stakeholders. Medical practitioners other than occupational health doctors should have a bigger role in the reporting and recognition of occupational diseases. This would require occupational health to form part of the training of all doctors. Most public health campaigns largely disregard the health impacts of working conditions. The mutual health insurance organizations have a very limited involvement in occupational health. The information they put out for their members seldom deals with occupational health matters. Their approach to prevention is focused on the individual. Their medical officers have no training in occupational health and provide little or no information to enable patients to identify the causes of occupational risk-related diseases.

The equality and occupational health institutions often seem simply to ignore one another's existence. And while data are to be found in the reports of preventive services, unfortunately they undergo no systematic statistical treatment.

## The framework around the reporting and recognition of occupational diseases

The keystone of the current legislative framework is the Occupational Diseases Act of 24 December 1963. It was amended several times, restated by a Royal Decree (statutory instrument) of 3 June 1970, and subsequently underwent further amendments. The main one for the purposes of this report was the introduction of Section 30a by the Act of 29 December 1990 introducing a so-called

**11.** New legislation transferred this task to the National Institute for Sickness and Invalidity Insurance (Inami) from 1 January 2010.

**12.** A joint national industry body with responsibilities for employment-related matters. The National Labour Council has two main responsibilities: adopting national collective agreements, and giving own-initiative or on-request opinions to the government and parliament. Its opinions or proposals can address all work-related issues of concern to employers and workers.

"open system" where any disease was potentially recognizable as an occupational disease if victims (or their entitled beneficiaries) could prove a direct, determining cause in the exercise of their occupation. This open system supplements the list system introduced in 1927 which prescribes a fixed number of work-induced medical conditions. Some of these were limited to certain sectors, the most disgraceful instance surely being that "diseases due to overstraining of the tendon sheaths, the peritendineum, muscular and tendinous insertions" were prescribed diseases only for performing artists despite being common among women workers exposed to repetitive movements in any sector of activity.

There is no statutory definition of an occupational disease. The Act merely refers back to regulatory powers: "The King shall draw up the list of occupational diseases giving rise to compensable harm". The lack of specific criteria means that a royal decree (regulations) laying down over-restrictive conditions for recognition of a specific disease would not be able to be challenged in the courts.

In fact, the exercise of these regulatory powers is tied up with the decisions of the FMP Management Committee in a sort of multi-tier delegation of powers. Most regulations are couched in quite general and sometimes vague terms. In most cases, the FMP adopts what can be very narrow interpretative criteria.

The list of occupational diseases was established by the Royal Decree of 28 March 1969, which has been repeatedly amended. In most cases, the disease is not defined, but its causal agent is specified. In some cases, it provides for compensation for certain specific disease conditions caused by a specific agent (e.g., lung cancer caused by asbestos, bone and joint disorders of the upper limbs caused by mechanical vibrations, etc.). The list currently contains about 150 items.

In a very few cases, there is a statutory presumption of exposure to certain risks in specified industries or occupations. Section 32 of the Act of 24 December 1963 provides that such presumptions may be established for both prescribed and open system diseases. In practice, the regulations refer only to prescribed diseases. The current regulations are contained in the Royal Decree of 6 February 2007, which is seriously flawed where cancer is concerned. For example, the fact of having worked in an asbestos cement materials factory creates a presumption of asbestos exposure for mesothelioma but not for lung cancer. There is no presumption of exposure for musculoskeletal disorders outside that of exposure to mechanical vibrations.

The system established is partially conditioned by 19th century medical understanding developed from the study of infectious diseases. Generally-speaking, a medical condition will be more readily prescribed if a causal agent resulting in one or more comparatively specific disease states can be identified.

Such an approach has several consequences:
— it takes more account of physical, often measurable, factors in working conditions like chemical, physical or biological agents;

— it makes it harder to take intangible factors related to work organization into account, like repetitive work, night work, work intensity or violations of dignity;
— it makes it harder to take account of diseases with a multifactorial aetiology. The very poor performance of the system in recognition of work-related cancers reflects this;
— it makes it extremely difficult to recognize work-related psychological problems. The early drafts of the bill on harassment and violence broached the possibility of recognizing occupational diseases related to these, but this was not taken up by either the Act of 11 June 2002 or its amending Act of 10 January 2007.

Getting new occupational diseases prescribed is a slow process. Where significant cost issues are involved, Belgium tends to lag behind many other industrialized countries. Silicosis is a well known case: it was not recognized as an occupational disease in Belgium until 1963, when most industrialized countries with a mining industry had already recognized it before the Second World War[13]. Mesothelioma caused by asbestos was prescribed only in 1982 in Belgium, compared to 1966 for the United Kingdom, 1976 for France, and 1977 for Germany.

In 2006, parliament introduced a new concept: the work-related disease[14] which, while not an occupational disease, might still become one in the absence of appropriate prevention. It was an invented terminology designed to avoid low back pain being recognized as an occupational disease ... while proposing that certain preventive measures should be financed by the FMP. The wording of s. 62a, para. 1, reflects some terminological confusion.

It states:
"The Fund may contribute to the prevention of occupational diseases by funding measures for the benefit of victims of a work-related disease.

Work-related diseases are diseases not referred to in ss. 30 and 30a which, according to generally accepted medical knowledge, may be partly caused by exposure to a harmful factor inherent in the work which is greater than that experienced by the general population, even though such exposure in the groups of persons exposed is not the predominant cause of the disease".[15]

The Minister of Labour's speech in the parliamentary debate on the passing of this statute offers no help in analysing this new concept: "A work-related disease is found in the general population, i.e., the population that is not exposed through their work. Any harmful factors resulting from occupational exposure

**13.** See Geerkens (2009).
**14.** Act of 13 July 2006 containing various provisions relating to occupational diseases, industrial accidents and returning to work, *Belgian Official Gazette,* 1 September 2006.
**15.** This provision did not generate much parliamentary debate. The representative of the Vlaams Belang Flemish independence party, Guy D'Haeseleer, voiced his satisfaction that "the government and social partners chose not to go too quickly in such a technical matter".

produce only a slight increase in the disease. Exposure to the occupational risk is not therefore the main cause of the disease, but a possible aggravating factor". Every one of the three criteria stated by the Minister is questionable. The first makes no sense: there is no occupational disease which does not also occur in the "general population". This is particularly so for women who spend a large amount of their time working outside of their paid occupation. There is no logical connection whatever between the two criteria. The statistical criterion ("slight increase") proves nothing in relation to causality. A nurse can be infected with the hepatitis virus in the course of her work (causal link) even if that contributes only marginally to the increased prevalence of the disease in the general population. The Minister concluded: "In practice, it is the Management Committee of the Occupational Diseases Fund that will be responsible for proposing work-related diseases and identifying the at-risk populations"[16]. These criteria may stand in the way of recognition of occupational diseases which occur in both the unpaid domestic work and paid work done by women.

The legislation clearly distinguishes two situations: reporting of occupational diseases and compensation claims.

## Reporting of occupational diseases

Occupational doctors have an obligation to report an occupational disease which they have diagnosed or been notified of by another doctor in one of four cases:
— it is a prescribed disease;
— it is not a prescribed disease in Belgium, but is on one of the two Schedules of the European Recommendation;
— it is a disease that is established or even suspected to have an occupational origin;
— in the event of a predisposition to one of these diseases[17] or early symptoms of one of these diseases if such diagnosis could affect the employment tenure or pay of the person affected.

The obligation to report occupational diseases also applies to the civil service.

The obligation is placed on occupational doctors by section 61 of the Occupational Diseases Act, re-enacted by the Royal Decree of 28 May 2003 on health surveillance. In practice, this obligation goes largely ignored by preventive services. This is a major and perennial problem that prevents a link being made between prevention and compensation.

**16.** Lower House, 4th session of the legislature 2005-2006, doc 51, 1334/004, 1 June 2006.
**17.** Notification of a predisposition remains in the regulations. But it conflicts with the Medical Examinations (Employment Relationships) Act of 28 January 2003. Even so, this provision is no more applied than the others: even end-stage cancers are not notified in most cases!

The lack of notification also has adverse consequences for those who have an occupational disease. It is an obstacle to claiming compensation. When the FMP receives a notification from a occupational doctor, it invites the worker to submit a claim for compensation. If the worker submits a claim within 120 days of the date of being invited by the FMP, the date of the occupational doctor's notification is taken as the basis for calculating compensation.

## Compensation claims

Different situations may open the way for compensation claims. The legislation uses the term "reparation" to refer to payments from the Occupational Diseases Fund. This idea of "making reparation" is quite old-fashioned terminology that reflects a view of life and health as saleable commodities. Money cannot make good, it indemnifies victims or their entitled beneficiaries, and in the event of loss of income, provides them with alternative resources.

Without going into details, compensation claims may arise out of three main situations:
— a temporary work disability;
— a permanent work disability;
— death.

The focus of analysis here will be claims arising out of **permanent work disability** which are by far the biggest in number and cost. In 2009, out of a total of almost 330 million euros in insurance expenditure by the FMP, payments for recognition of an occupational disease causing a permanent work disability accounted for almost 188 million euros (56.9%). Awards for a temporary disability accounted for only about 5 million euros (1.5%). FMP spending related to deaths stood at around 62 million euros (18.7%). Most of these deaths were the consequence of an already recognized disease that had resulted in a permanent work disability. Just over 68 million euros (20.6%) was spent on preventive transfers, which mainly concerns pregnant women and is not a direct part of the occupational disease compensation scheme[18].

The FMP plays only a limited role in health care, confined to reimbursing co-payment charges[19] and a few other expenses not borne by the sickness insurance system. In 2009, health care accounted for only about 2% of all insurance

**18.** Preventive transfers for pregnant workers stopped being financed by the FMP in January 2010 and are now funded by the Inami (the sickness and disability branch of social security for employees). This solution has the advantage of eliminating discrimination between pregnant workers by whether the exposure that was the reason for their transfer was recognized as potentially causing an occupational disease or not. The FMP would only countenance payments for prescribed exposures, diseases and occupations. Other cases of preventive transfer – still paid for by the FMP - concern only a few dozen people a year (27 women and 59 men in 2009).

**19.** The co-payment charge is the out-of-pocket payment made by patients after reimbursement by the social security scheme of the cost of a visit to the doctor or a health care medical procedure.

costs paid for by the Fund. This aspect, along with vaccinations, other preventive measures and applications for review, will not be addressed in this report.

Compensation claims must be submitted by the victims or their entitled beneficiaries. The FMP rules on all applications. Challenges to its decisions must be brought in the employment tribunals and courts.

There are specific rules on applications to the Asbestos Fund. The main differences from the ordinary occupational diseases scheme are:
— compensation can be awarded for environmental exposure as much as exposure through work. This wider scope also includes unpaid domestic work;
— compensation can be awarded for occupational exposure regardless of employment status (employees, civil servants, self-employed).

The Asbestos Fund does not, however, give equal treatment to those exposed as employees and those exposed in other circumstances (e.g., through unpaid domestic work). Only through the FMP do employees get completely free medical care, disability assistance, and compensation for funeral expenses.

The compensation awarded by the FMP is proportional to salary for temporary disability. It is a fixed sum determined by a disability rate for permanent work disability. It is calculated in relation to the loss of employment opportunity and does not compensate for all the harm that a disease may do, be it psychological distress or physical disfiguration. The low disability rates mean low compensation rates: reduced to half for a rate less than 5%, and a quarter for between 5 and 9%[20]. Taking the recognized cases as a whole, the probability of women being assigned low work disability rates is higher than for men.

## The Community framework for occupational diseases

The need to harmonize the systems for recognition and reporting of occupational diseases emerged very early on in Community social policy. On 23 July 1962, the European Commission adopted a Recommendation to achieve that aim[21] addressed to the then six Member States of the European Economic Community.

The importance of a uniform system of recognition of occupational diseases was seen both as a social priority and as a means of avoiding distortion of competition and facilitating the free movement of workers. The situation in Belgium was apparently the focus of reasonable concern among its European partners. Tens of thousands of Italian miners who had worked in the Belgian mines were suffering from silicosis which was not yet recognized as an occupational disease. Under pressure from left-wing parties and the trade unions,

**20.** These reductions were introduced by the Act of 31 July 1984 introducing a set of "economic recovery" measures at a time of crisis.
**21.** *Official Journal of the European Communities*, 31 August 1962, p. 2188.

Italy was gearing up to pass Act No. 1115 of 27 July 1962 to allow miners who had contracted silicosis in Belgium to receive compensation from the Italian social security scheme if they returned to live in Italy. This Act was intended to be a transitional measure until Belgium recognized silicosis as an occupational disease. But the 1962 Community Recommendation also drew directly on International Labour Organisation Conventions and Recommendations.

The Occupational Diseases Recommendation of 23 July 1962 had a compensation focus. It fell into three parts. Annex 1 established a European uniform Schedule of diseases or agents that can cause them. The diseases in this list were those for which Member States must provide compensation. A second Schedule (Annex 2) listed diseases that had to be notified to enable their possible future inclusion in the first Schedule.

As well as establishing these lists, the Commission called for systems to grant recognition to all diseases whose occupational origin could be sufficiently proved. This introduced what is known as a mixed system. Where prevention is concerned, the 1962 Recommendation stressed the link between recognition and the special focus it entailed on a risk. The Recommendation also mapped out the way forward for Community action. Part of this would be to achieve uniform qualifying conditions and benefit levels for occupational diseases. But it would also involve developing preventive strategies based on improved medical and scientific knowledge. The Community reporting system established should have given a basis for between-country comparisons.

The Recommendation of 23 July 1962 was followed by a number of other Recommendations.

— **the Recommendation of 20 July 1966**[22] whose main aim was to lift the restrictions on recognition of prescribed diseases based on criteria like specific clinical signs, specific activities or types of jobs, a minimum exposure duration, or a maximum compensation claim time limit between exposure and diagnosis of the disease. The 1966 Recommendation was clear that in the current state of knowledge in the field of occupational medicine and the increasingly sophisticated investigative methods available to experts, it had become necessary to scrap most of the mandatory restrictions on the right to compensation because the current restrictive conditions were generally arbitrary as was shown by the fact that where such conditions were found for the same disease in different national laws they were far from identical. In order to remove most of these restrictive conditions, the Recommendation adopted an annex on cases of harmful agents and occupational diseases where the restrictions set out could be provided for. The Recommendation also called for lists unique to agriculture to be scrapped, and for a mixed system to be established for non-prescribed diseases. It recommended that the insurer should automatically take all necessary steps to identify the occupational origin of the disease, and called for a system of national reports

**22.** *Official Journal of the European Communities*, 9 August 1966, p. 2696.

to be submitted every two years by Member States to enable a periodic review of the European list.

— **the Recommendation of 22 May 1990**. This updated the European Schedules for the first time in 28 years, which were meant to have been regularly updated every two or three years, but no longer laid down any restrictions. It noted that most Community countries were still not applying the mixed system: only Denmark and Luxembourg's systems seemed to comply with the 1962 and 1966 Recommendation guidelines. It concluded with a request to "the Member States to inform it, at the end of a three-year period, of the measures taken or envisaged in response to this recommendation. The Commission will then examine the extent to which this recommendation has been implemented in the Member States, in order to determine whether there is a need for binding legislation".

— **the Recommendation of 19 September 2003**[23] which replaces the 1990 Recommendation and is based on the same principles: a schedule of diseases for which recognition should be guaranteed and a schedule of compulsorily notifiable diseases, recognition of which is discretionary in each country. Also, any disease not in either schedule should be able to be recognized under the open system.

The new Recommendation generally follows the Commission's original 2001 proposals. However, some union demands were taken into account and included in the final version.

These focused essentially on three points:

— national occupational disease statistics should be gender-disaggregated;

— much greater involvement by public health systems and medical personnel in the reporting of occupational diseases;

— new diseases connected with musculoskeletal disorders - carpal tunnel syndrome and three categories of bursitis - to be expressly included in the schedule of occupational diseases.

On other points, the initial proposals were watered down under pressure from employers with the backing of different governments. Cancers of the larynx (throat cancers) were moved from the first to the second schedule[24]. Spinal column disorders caused by load-carrying were originally included in the second schedule, but dropped from the final version. And yet the EU Manual Handling of Loads Directive establishes the link between load-carrying and back injuries. The economic stakes are high, as they incur significant costs to health systems and victims.

The Community framework for occupational diseases is soft law, based on non-binding instruments. It is now nearly half a century since the first Recommendation was adopted, yet the creation of a mandatory harmonized

**23.** *Official Journal of the European Communities,* L 238 of 25 September 2003.

**24.** Laryngeal cancer caused by asbestos has been prescribed in Belgium since May 2002, but the conditions are highly restrictive.

framework for the recognition of occupational diseases in the EU is still not on the agenda. This partly explains why the EU strategy for health at work 2007-2012 set a quantitative target only for reducing work accidents.

A study of selected EU countries yields the following trends for the years 1990 to 2006.

Table 1 **Trend in number of recognized occupational diseases per 100 000 workers (1990, 2000 and 2006)**

| | 1990 | 2000 | 2006 |
|---|---|---|---|
| Luxembourg | 8 | 14 | 25 |
| Italy | 93 | 33 | 38 |
| Germany | 35 | 49 | 40 |
| Austria | 78 | 42 | 42 |
| Belgium | 186 | 112 | 54 |
| Portugal | – | 27 | 70 |
| Denmark | 90 | 124 | 98* |
| Spain | – | – | 103 |
| Sweden | 1242 | 138 | 267 |
| France | 44 | 177 | 282 |

* 2005 data / Source: Eurogip (2009)

This range from one to ten is unrelated to working conditions. Even in countries with the highest recognition rates, the vast majority of work-induced illnesses are not recognized as occupational diseases.

Among the countries covered by the Eurogip data[25], Belgium was positioned second in 1990, fourth in 2000 and sixth in 2006. Compared to France, Belgium recognized four times more occupational diseases relative to the population covered in 1990, but five times fewer in 2006. Even looking at the data on a purely national basis reveals a significant downward trend from 184 diseases recognized per 100 000 workers in 1990 to 54 in 2006, despite the inclusion of non-prescribed diseases in the system and an increase in the number of prescribed diseases.

What can explain the sharp drop in the number of cases of new occupational diseases recognized in Belgium? To suppose a steady improvement in working conditions would be ingenuous. Arguably more realistic would be to suggest that the recognition system is increasingly less accurately reflecting real changes in working conditions. Its recognition criteria still partly hark back to the conditions of the previous generation of male industrial workers. It has not fully accommodated the changes in sectors of activity, working conditions and knowledge about the relationship between work and health.

**25.** Created in 1991, Eurogip is a French organization researching into the insurance and prevention of occupational accidents and diseases in Europe. It publishes regular statistical and legal information on recognition of occupational diseases in different European countries.

National occupational disease recognition systems may differ widely, but they almost all have one thing in common. They are highly discriminatory against women.

The percentage of women for whom an occupational disease is recognized is below 10% in the United Kingdom. In most European countries it is between 20 and 30%. Only in the Nordic countries are the percentages somewhat more balanced.

# Section 2
# A gender analysis of the occupational disease data is needed

Since 2002, the FMP's annual reports have contained separate data for men and women in almost every statistical table. But it has never done a gender analysis of that data. In other words, a number of crude indicators are available, but there are many methodological difficulties to using them. More generally, the interpretation issues stem from an essentially administrative approach to the relationships. Quantitative data are given under different headings, but no analysis is done to identify problems or improve prevention policies.

## Problems and limitations

The main problems encountered are as follows.

**1.** The existing data are limited to the private sector and local and provincial authorities (LPAs). There is no consolidated data that would give an overall view including all public servants. This limitation does not apply to the statistics on occupational diseases reported by occupational doctors. Unfortunately, the failure of most preventive services to fulfil this statutory requirement renders the reporting data unusable.

**2.** The FMP reports categorize diseases by reference to two classification systems included in Annexes 1 and 2 of this report. One places diseases into categories identified by numerical codes taken from the regulation list of prescribed diseases. This distinguishes five categories (plus a mixed bag of medical conditions unclassifiable into any of these categories) and approximately 150 numerical codes that correspond to what are called tables in the French system. The codes may refer to a specific medical condition associated with a single exposure (e.g., laryngeal cancer caused by asbestos), or they may refer to an exposure without defining lists of actual diseases (e.g., occupational diseases caused by nickel and its compounds). The precise conditions for recognition are rarely laid down in the regulations. This leaves very wide discretion to the Fund's administration bodies.

The Fund also uses a second classification system for statistical purposes (see Annex 2) in the form of a single-letter alphabetical code that can designate a specific disease (e.g., H for viral hepatitis) or a group of diseases (e.g., D for skin diseases).

The numerical system and the alphabetical system do not necessarily correspond. A skin condition may fall under a group 1.1 disease (occupational diseases caused by specific chemical agents) or a group 1.2 disease (occupational skin diseases caused by substances and agents not elsewhere classified). Under the open system, only the latter classification exists since, by definition, no reference is made to prescribed diseases and conditions.

One big drawback of the data compiled by the FMP is that it does not always enable diseases to be grouped into broad categories that would make it easier to link compensation and prevention. So, there is no overall data for occupational cancers[26]. The FMP's letter code classification does not include cancers that fall into different categories of disease which do not distinguish relatively minor illnesses from cancers (e.g., respiratory diseases, general illness, etc.). Only a few cancers – those caused by asbestos - are explicitly included. The reports contain no data for the dozens of other exposures to carcinogens commonly found in workplaces (e.g., benzene, formaldehyde, silica, etc.).

**3.** The data do not identify indicators of frequency for the insured population. In other countries, and in some comparative analyses, data can be found for the ratio of the number of occupational diseases to all workers covered by a system of compensation for them, or the volume of hours worked. The clear advantage of this approach is to give a time trend picture that takes into account demographic changes in the study populations. Clearly, however, frequency indicators must be developed with caution, allowing for what may be long latency periods between occupational exposures and the onset of the disease, and considering the fact that compensation claims may not be introduced until long after the disease is first observed to be present. To overcome these limitations, it is highly recommended that statistics be compiled on exposures to occupational risks and checks be done on occupational doctors' compliance with their obligation to notify occupational diseases. At present, no such check is done.

In Belgium, the compilation of exposure statistics could be based on the health surveillance regulations. Each employer must compile lists corresponding to the jobs and workers subject to health surveillance. The Federal Ministry - Employment, Labour and Social Dialogue could produce annual statistics by which to monitor these exposures. This would provide relatively complete data for physical, chemical and biological agents and more roughly accurate data on certain aspects of work organization (night work, manual handling, VDU work, ergonomic factors or what the legislation calls psychosocial workload). This would also give a better idea of the extent to which the obligation to provide a number of categories of workers with health surveillance is being fulfilled.

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**26.** Data on cancers are never systematically presented in FMP documents. By contrast, a comparative European report by Eurogip (2010) contains summary data for Belgium covering the period 2001-2008. For this research, the FMP's Karim Wilmotte kindly produced a table of all cancers recognized as occupational diseases between 2000 and 2010. These data are shown below in Table 19.

**4.** To the best of my knowledge, there is no statistical research in Belgium on the working conditions-attributable fraction of mortality or morbidity either generally or for specific diseases[27]. Such data would be of great use in measuring the performance of the occupational diseases reporting and recognition system. The only data I could find for Belgium are those of the International Labour Organisation, extrapolated from original studies in other countries and relating only to work-induced mortality. They also have very significant limitations from a gender perspective. The working conditions-attributable fraction of mortality has been calculated on the basis of the existing epidemiological literature, which is prone to underestimate the impact of working conditions on women's health.

## Notification of occupational diseases

The statistics for notifications of occupational diseases are disturbing. From them, the reasonable inference can be drawn that occupational doctors are effectively shirking wholesale their obligation to notify these diseases. They also raise the issue of cooperation between the other health stakeholders and occupational doctors. It seems likely that a significant number of work-induced medical conditions are being diagnosed by general practitioners or specialists but no communication is taking place with occupational doctors such that this information cannot be used to improve preventive measures.

It should be borne in mind that the obligation to notify extends to all diseases prescribed in the Belgian list, both schedules of the EU Recommendation, all diseases that are at least suspected to have an occupational origin, and all situations where there is a predisposition or early symptoms. It is of special importance from an epidemiological standpoint to report diseases that are not yet included in the Belgian schedule of occupational diseases as this would help add proactivity to the system.

Around 1500 cases a year are notified. The numbers have declined slowly but steadily over the past fifteen years: 2113 notified occupational diseases in 1995 down to 1391 in 2009. What makes this finding particularly alarming is that the baseline situation is already very bad.

Looking at distribution by sector of activity, annual notifications exceed 100 in only two areas:
— health and social work;
— public administration and defence, and compulsory social security.

The geographical distribution also shows inexplicable variations: Brussels Capital's share of such notifications amounts to less than 4%, against nearly 10% for Flemish Brabant (2009 figures). The distribution by occupation simply confirms the wholesale avoidance of their obligation by occupational

**27.** Such data generated by varying methodologies are found in many countries. Literature was available for Australia, Spain, the United States, Finland, France and Switzerland.

doctors. There are more notifications among health professionals and nursing staff than among building trades. This makes the instrument utterly useless as guidance for prevention.

As regards the gender breakdown, the proportion of women is in the order of 45%. This is mainly due to the fact that health and social services are one of the few sectors where a minimum of occupational diseases are notified, although it is small consolation to see that approximate equality between men and women exists only in an area where the figures reflect a near complete lack of action by the preventive services!

The diseases reported reflect a sort of cautious conservatism in that the few diseases reported tend to be prescribed diseases. Annually, about 200 to 300 diseases that are not prescribed in Belgium are reported[28]. Notification of a cancer seems to be absolutely exceptional.

Another disturbing fact is the late stage at which these odd few notifications are made. More than half the notifications for men are for those in the 44-65 age bracket, while for women, more than half are in the 40-65 age bracket. This is inexplicable given the importance for prevention of reporting the first signs of any disease which the occupational doctor suspects may be work-induced. Also, the number of notified diseases for those aged 65 and over is next to nil. This raises the issue of post-employment health monitoring.

Table 2 **Mandatory occupational disease notifications by occupational doctors**

| | Men | Women | Total | Number of non-prescribed diseases |
|---|---|---|---|---|
| 1994 | n.i. | n.i. | 2118 | 157 |
| 2002 | 1017 (62.8 %) | 602 (37.1 %) | 1619 | 278 |
| 2003 | 1094 (59.4 %) | 746 (40.5 %) | 1840 | 285 |
| 2004 | 911 (50.1 %) | 906 (49.8 %) | 1817 | 244 |
| 2005 | 870 (52.8 %) | 777 (47.1 %) | 1647 | 253 |
| 2006 | 852 (54.1 %) | 721 (45.8 %) | 1573 | 257 |
| 2007 | 759 (49.1 %) | 784 (50.8 %) | 1543 | 254 |
| 2008 | 782 (52.9 %) | 696 (47.1 %) | 1478 | 216 |
| 2009 | 742 (53.3 %) | 649 (46.6 %) | 1391 | 242 |

Sources: FMP Annual Reports

**28.** The FMP statistics give no details on non-prescribed diseases.

## First compensation claims

This section looks at the medical conditions for which a victim (or their entitled beneficiaries) made a compensation claim.

The review is confined to compensation claims for a permanent work disability. The trend in compensation claims for a permanent work disability may seem counterintuitive: despite the creation of an open system that allows claims to be made for non-prescribed diseases (or ones that do not meet the list criteria) and the extension of the prescribed list to a larger number of diseases, there is a sharp drop in first claims between 1991 and 2010. In the private sector, they fell from 9314 to 5448 (or 8122 and 4922 respectively taking only new cases).

Women accounted for 26% of first claims in 2010. This proportion is up from the first claims submitted in 2001. Over the decade, the figures show that first claims from women have remained relatively stable in absolute terms, while those for men have declined.

Women's share of claims varies widely with the disease. Women dominate two of the sixteen disease groups identified by FMP statistics: Group C - carpal tunnel disorders, and Group D - skin diseases.

Table 3 **First claims, private sector, list system + open system, 2010**

| | Men | Women | Total |
|---|---|---|---|
| **All conditions** | **4022** | **1426** | **5448** |
| Deafness | 665 | 15 | 680 |
| Haematopoietic system | 13 | 2 | 15 |
| Carpal tunnel | 252 | 367 | 619 |
| Skin diseases | 124 | 203 | 327 |
| Mainly tear overuse of the spinous processes | 0 | 0 | 0 |
| Viral hepatitis | 1 | 3 | 4 |
| Low back disorders | 863 | 147 | 1010 |
| Bone, joint diseases of the upper limbs | 187 | 15 | 202 |
| Ear-nose-throat diseases other than deafness | 50 | 14 | 64 |
| Respiratory system | 782 | 159 | 941 |
| Bone, joint, intervertebral disk disorders | 502 | 131 | 633 |
| Tendinitis | 450 | 330 | 780 |
| Diseases of the periarticular sacs | 22 | 0 | 22 |
| Vascular disease | 12 | 4 | 16 |
| General illness (infectious, kidney, nerve disease, diseases not elsewhere classified) | 95 | 36 | 131 |
| Eye disorders | 4 | 0 | 4 |

Source: FMP, annual report, 2010: 26

A cross-reading of these data against the diseases notified points to the existence of a significant gap between compensation claims and work-induced diseases. Mental health disorders are almost completely absent, while musculoskeletal disorders are under-represented.

The likelihood is that system blockages are feeding back onto the making of claims by potential beneficiaries. An anticipated rejection, or a procedure that seems too complicated for an uncertain outcome, effectively stops a claim from being made. Such a deterrent effect is understandable. Where it is hard to get a disease recognized as an occupational disease, victims are put off from having to deal with the establishment[29]. In the case of serious diseases like cancer, patients and their relatives have no wish to embark on an obstacle course of uncertain outcome in which each step can only make the victim's suffering worse.

## The Fund's decisions on first compensation claims

### List system

Since 1993 there has been a dramatic fall in the number of first compensation claims accepted for permanent work disability from prescribed diseases in the private sector. Totalling 4,888 in 1992, the number dropped some 80% to 898 according to the data available for 2010. Between 2006 and 2010, the figures appeared to show a levelling off at an extremely low level of between 840 and 900 accepted claims a year. Women invariably account for less than 10% of this total. The average age at which women claimants' claims are accepted is significantly lower than for men (age 45 against 62 in 2010).

Statistical analysis of rejected claims is severely hampered by the fact that while the statistical part of the FMP's annual reports distinguishes accepted claims for temporary disabilities from accepted claims for permanent disabilities, all rejected claims are lumped together regardless of the type of work disability. Year on year, twice to two and a half times as many claims may be rejected as are accepted in the list system. In 2009, there were a total of 1,236 accepted claims for temporary (386 cases, 49% women) and permanent (850 cases and 8.7% women) work disability, and 2,505 rejected claims (of which about 20% women).

### Open system

The statistics seem to suggest that the open system has never operated as a supplementary scheme for compensating occupational diseases that did not meet the often strict prescribed disease criteria, but has had only a marginal corrective action.

Over time, system performance has even declined. Breaking down the years for which gender-differentiated data are available into three-year periods, accepted claims for permanent work disability decline from 175 in 2001-2003 to 79 in 2004-2006 and 63 in 2007-2009. Women represented 34% of the total

**29.** Lippel (2007) analyzes the negative effects of the compensation claim process in Quebec. Her conclusions seem highly relevant to Belgium.

in the first period, just short of 27% in the second period and 17% in the third period. This suggests that the decline in system performance has been even more damaging to women than to men.

Table 4 **Number of accepted first claims, permanent work disability in the private sector + local and provincial authorities (LPAs), open system**

| | Men | Women | Total |
|---|---|---|---|
| 2001 | 29 | 7 | 36 |
| 2002 | 55 | 34 | 89 |
| 2003 | 31 | 19 | 50 |
| 2004 | 13 | 6 | 19 |
| 2005 | 23 | 7 | 30 |
| 2006 | 22 | 8 | 30 |
| 2007 | 18 | 3 | 21 |
| 2008 | 18 | 5 | 23 |
| 2009 | 16 | 3 | 19 |

Sources: FMP annual reports

The statistical analysis of rejected claims faces the same obstacles as for the list system. The FMP annual reports do not distinguish rejected claims by whether they relate to permanent or temporary disabilities, or simply medical treatments. Of all the decisions taken, about 90% of claims were rejected. In the private sector in 2009, there were 601 rejected claims, about a third of them women. There were 71 accepted claims (including 20 women), but women accounted for only 18% of the 19 claims accepted for permanent work disability.

## Overall compensation for permanent work disabilities

### List system

To use an economic metaphor, the data on all permanent work disabilities allow the operation of the system to be analysed in terms of stock rather than flow. Notifications, first compensation claims and decisions on them are activities measurable on an annual basis. They are usable to analyze how our system for the recognition of occupational diseases reflects the trend in work-induced illnesses.

The data on compensation for permanent disabilities give an assessment covering a much longer period, reflecting notifications, claims and decisions that may have occurred long ago.

The codes corresponding to the largest number of cases concern diseases that primarily reflect the risks of historically-dominant industrial activities.

Silicosis is a case in point. The fact that there are relatively few new cases is largely down to the vanishing mining industry. The conditions for recognition

have not changed. In 2009, with 9644 cases, compensation for permanent disability attributable to silicosis accounted for more than 15% of all cases and over 25% of total amounts paid.

The case of back injuries is different. While this disorder is anything but a thing of the past, the current conditions for recognition are not appropriate in most cases. In 2009, there were 13,620 cases of permanent incapacity for back injuries caused by mechanical vibrations. Added to this are more than 2700 cases for lower back, back and upper limb injuries caused by mechanical vibrations. In 2002, these various codes were replaced with new codes that result in only a very small number of compensation payouts. The FMP has developed much more restrictive criteria. Only workers with significant injuries which manifested before the age of 40 can be compensated for low-back injuries caused by mechanical vibrations. The new definition excludes injuries caused by jackhammer use. This revision resulted in a sharp drop in the number of new cases compensated. The criteria for exposure to mechanical vibrations exclude load-carrying and postural stresses. This is a big factor in excluding women from the compensated back and low back conditions.

Table 5 **Private sector, list system, all compensations for permanent work disability, 2009**

| | Men | | | Women | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| Occupational Diseases * | Number | Amount** | Ave. PWD % | Number | Amount | Ave. PWD % | Number | Amount | Ave. PWD % |
| Group 1.1 | 2032 | 843 | 22.8 | 784 | 165 | 13.6 | 2816 | 1007 | 20.2 |
| Group 1.2 | 1799 | 470 | 14.4 | 1951 | 520 | 15.2 | 3750 | 990 | 14.8 |
| Group 1.3 | 13 039 | 4390 | 25 | 465 | 129 | 18.6 | 13 504 | 4519 | 24.7 |
| Group 1.4 | 52 | 32 | 33.6 | 168 | 63 | 22.0 | 220 | 95 | 24.7 |
| Group 1.6 | 35 905 | 6620 | 13.5 | 643 | 117 | 12.9 | 36 548 | 6737 | 13.5 |
| Group 1.7 | 99 | 101 | 41 | 321 | 97 | 13.3 | 420 | 198 | 19.8 |
| **Total** | **52 926** | **12 456** | **16.8** | **4332** | **1090** | **15.1** | **57 258** | **13 546** | **16.6** |
| **Average age** | **68 years** | | | **53 years** | | | **67 years** | | |

* See Annex 1. / ** For clarity, all amounts are rounded off in thousands of euros. / Source: Annual Report, 2009: 149-153

This table requires some comment. In terms of "stock", the gender imbalance in the list system of occupational diseases is blindingly obvious. Women account for less than 8% of all those who receive compensation payments for permanent work disability. Also, recognized work disability rates are on average lower for women: 15.1% against 16.8%. This difference recurs in the great majority of diseases. It appears not to stem from primarily medical criteria. It is difficult to account for why diseases as different as viral hepatitis, tuberculosis, solvent-induced psycho-organic syndromes or osteoarticular disorders result in work disability rates that are higher on average for men. It presumably reflects the complex social value attached to different factors that result in work disability rates being determined by taking into account physiological damage, professional qualification, the ability to compete in the labour market and other factors besides.

The odd exception offers little clarification. Arguably, it could reasonably be conjectured that, in disputes, both the FMP and the employment courts and tribunals entrench a devaluation of women's work through the use of purportedly gender-neutral criteria. Belgium's Supreme Court of Appeal defines the legal position in particularly bald terms: "It is the victim's lost or reduced economic value on the general employment market that is compensated by the benefit which corresponds to the rate of permanent work disability (physical and socio-economic factors) caused by the occupational disease"[30]. In a later case, the Court held that: "The lost or reduced economic value on the general employment market includes a percentage of disability due to the physical factor, to which should be added the percentage related to the influence of socio-economic factors to assess the overall rate of permanent work disability"[31].

The differences in amounts are the sum of the combination of two factors of inequality: the number of recognized cases and the lower average economic value attributed to women's work. The allocation of amounts results in women being accorded less than 8% of all compensation for occupational disease-related permanent work disability.

It can therefore be argued that the data on permanent incapacities provide the makings of an overall assessment of the historical and social development of a system of occupational diseases around medical conditions that are specific to or more common in men. In other words, it reflects a massive invisibility of damage to women's health. The trend over time holds out few grounds for optimism. Between 2002[32] and 2009, the total number of women private sector workers for whom a permanent work disability was recognized under the list system rose by just over 600 units. It cannot be told from the FMP's statistics whether this represents an improved share of all the women potentially within the system (i.e., all female private sector employees plus women who were employees for a period of their lives).

## Open system

The table below gives an overall picture of the operation of the open system. It includes all private sector workers for whom an occupational disease was recognized and compensated in 2009. Because compensation for death rarely exceeds five cases per year, these figures show little significant variance from the total number of cases of permanent work disability recognized over twenty years.

**30.** Judgement of 29 September 1986, *Pasicrisie,* I, p. 122. Ironically, this decision resulted in a finding in favour of a worker who had reached retirement age. Nevertheless, it could not be more explicit about the perpetuation of inequalities entailed by compensation based on a victim's "economic value".

**31.** Judgement of 28 May 1990, *Chroniques de Droit social,* 1991: 12.

**32.** The reports published prior to 2002 give no indication of the gender of persons for whom a permanent work disability has been recognized.

Table 6 **Permanent disability: open system, all cases compensated in 2009**

| | Men | | | Women | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | No. | Amount | Average PI % | No. | Amount | Average PI % | No. | Amount | Average PI % |
| Carpal tunnel | 2 | 102 | 4.5 | 0 | – | – | 2 | 102 | 4.5 |
| Low back disorders | 1 | 402 | 16 | 0 | – | – | 1 | 402 | 16.0 |
| Ear, nose, throat diseases other than deafness | 12 | 5847 | 23.8 | 16 | 4218 | 12.4 | 28 | 10 065 | 17.3 |
| Respiratory system | 41 | 14 076 | 17.6 | 38 | 12 241 | 15.5 | 79 | 26 316 | 16.6 |
| Bone, joint, intervertebral disk disorders | 146 | 39 490 | 14.4 | 38 | 10 050 | 14.1 | 184 | 49 450 | 14.3 |
| Tendinitis | 251 | 30 423 | 7.3 | 108 | 8525 | 5.6 | 359 | 38 948 | 6.8 |
| Vascular disease | 10 | 1250 | 7.3 | 1 | 93 | 10.0 | 11 | 1343 | 7.5 |
| General illness (infectious, kidney, nerve disease not elsewhere classified) | 2 | 2063 | 47.5 | 2 | 2381 | 48.0 | 4 | 4445 | 47.8 |
| **Total** | **465** | **93 653** | **11.1** | **203** | **37 507** | **10.0** | **668** | **131 161** | **10.8** |

Source: FMP, annual report, 2009: 166

The open system was introduced in 1990. We now have sufficient perspective to see how far this system can make up for the failings of the list system. A "stock" analysis of all those for whom a permanent work disability has been recognized prompts the following observations:

1. The overall performance of the open system remains poor. In almost twenty years, only a few hundred people have succeeded in getting a permanent work disability recognized. The diseases recognized fall mainly into two groups: bone, joint and disc diseases and tendinitis. These are conditions for which a change to the list criteria is arguably essential[33]. From this angle, the open system does no more than make marginal correctives to some of the list system's worst shortcomings.
2. The open system perpetuates gender inequalities in the recognition of occupational diseases, albeit to a lesser extent (than the list system) in terms of share of recognized cases (about 30% of women), but more significantly so in the work disability rates found relative to comparable diseases.
3. That there were no recognized cases of women with carpal tunnel syndrome[34] or low back disorders is inexplicable looking at the data from other countries for the prevalence of these work-induced illnesses.
4. Diseases recognized in the open system tend to be for quite low work disability rates. Of 668 recognized cases, 372 related work disability rates below 10% and 292 to rates of between 10 and 20%.

**33.** The 2008-2012 well-being at work strategy provides for tendinitis to be made a prescribed disease for all the occupations concerned. At present, it is not a recognizable prescribed disease for performing artists. As of October 2011, the change had not yet been introduced.

**34.** Carpal tunnel syndrome is a prescribed disease in the category of conditions classified as code 1.605.51. In 2009, all cases where a permanent work disability was recognized in this group totalled 336 men and 134 women. Once again, the work disability rate for women is below that of men (6.9 against 8.2). Accepted claims for temporary work disability were likewise very low: 40 women and 5 men in 2009.

5. The open system seems to afford virtually no scope for achieving recognition of occupational cancers.
6. The scope for diseases affecting mental health also seems to be next to nil[35].
7. Total compensation paid for permanent incapacities recognized under the open system is equivalent to just under 1% of all compensation for permanent disability. This confirms the marginal role of the open system which is an insuperable obstacle course for most potential claimants.

## Derived rights: spouse's pension

While women are the biggest losers as workers in the occupational diseases system, they undeniably enjoy a privileged position as wives, or more accurately as widows. Of a grand total of just over 4.8 million euros paid out in compensation as pensions to entitled beneficiaries in the list system for the private sector in 2009, widows received 4.65 million, widowers just over 32 000 euros and orphans approximately 150 000 euros. The benefit to women from their family situation is obviously limited by the very low amounts paid out to them.

## Accepted claims under the Asbestos Fund

The Asbestos Fund came into operation in 2007[36]. The Fund compensates a number of diseases for people exposed to asbestos regardless of occupational status or source of exposure. The exclusion of asbestos-induced lung cancers is one of the biggest limitations of the system set up. The data from the French compensation fund for asbestos victims (FIVA)[37] show that for each case of mesothelioma compensated, there are about two cases of asbestos-induced lung cancers. In Belgium, an asbestos-induced lung cancer can be recognized as a prescribed occupational disease, but the criteria are quite restrictive. On average, the number of recognized lung cancer cases is about half the number of mesothelioma cases. This proportion is abnormally low in light of the epidemiological data.

### Compensation for mesothelioma

Between 1 April 2007 and 31 December 2010, there were 1043 accepted claims (pensions and lump sums awarded) in 688 cases.

35. According to a Eurogip survey (2004), only two cases were recognized by the FMP between 1996 and 2002, compared to more than 100 cases in Portugal and 600 in Sweden during the same period.
36. The FMP's annual reports give no gender-disaggregated data for the Asbestos Fund. My thanks to Anne Kirsch who kindly compiled the tables in this section.
37. The FIVA's annual reports are available at http://www.fiva.fr

Table 7 **Mesothelioma cases compensated by the Asbestos Fund, 1 April 2007 to 31 December 2010**

| Claimant status | No. of pension awards | No. of lump sum awards | Number of accepted claims (award of pension + award of lump sum) | No. of recognized cases | No. of women |
|---|---|---|---|---|---|
| **Occupational** | | | | | |
| Employee | 445 | 312 | 757 | 483 | 15 |
| Public sector | 11 | 4 | 15 | 11 | 0 |
| Belgian army | 4 | 2 | 6 | 4 | 1 |
| LPAs (local and provincial authorities) | 7 | 1 | 8 | 7 | 0 |
| SNCB* | 11 | 4 | 15 | 12 | 1 |
| Belgacom** | 3 | 2 | 5 | 3 | 0 |
| Self-employed | 28 | 10 | 38 | 29 | 6 |
| **Non-occupational** | | | | | |
| Legal partner | 16 | 8 | 24 | 16 | 11 |
| Near an asbestos-using factory | 12 | 3 | 15 | 12 | 9 |
| Hobby | 20 | 9 | 29 | 21 | 10 |
| Other | 93 | 38 | 131 | 90 | 35 |
| **Grand Total** | **650** | **393** | **1043** | **688** | **88** |

* SNCB: Belgian National Rail / ** Former state-owned telephone company, now privatized. / Source: FMP

That works out at 650 pension awards and 393 lump sum awards for 688 cases recognized under the Asbestos Fund.

Of the 650 pension award decisions, 83 were for women and 567 for men.

Of the 393 lump sum award decisions, 37 were for the death of a woman, but in 32 of these cases, a pension was also awarded.

In all, therefore, women accounted for 88 of the 688 recognized cases of mesothelioma - about 13%. Women make up the majority of cases in two specific categories: legal partners (11 women out of 16 cases) and people living near an asbestos-using company. Women's share of occupational exposures is around 4%.

It is hard to say to what extent this relatively low percentage of women might reflect objective differences in the gender prevalence of mesothelioma in Belgium, as I know of no study on the matter.

A usable benchmark is the Italian mesothelioma register, which is among the best in Europe[38]. For pleural mesothelioma, women account for about one quarter of cases; for peritoneal mesothelioma, they represent about 40% of cases; for all forms of mesothelioma, women make up 27.5% of cases.

**38.** ISPESL (2010) *Il registro nazionale dei mesoteliomi. Terzo rapporto,* Rome. See especially chapter 8 on cases of mesothelioma among women.

French data from the National Mesothelioma Surveillance Programme yield fairly similar estimates for pleural mesothelioma - depending on the year, women account for 20%-25% of all pleural mesothelioma cases recorded in France[39]. Pleural cancer mortality data for France show a comparable order of magnitude: women account for about one quarter of all deaths. Based on these data, the fact that the Asbestos Fund compensates about one eighth of women as mesothelioma victims does not seem to reflect purely objective data on mesothelioma prevalence. It is a question mark that requires closer investigation.

## Compensation for asbestosis

Between 1 April 2007 and 31 December 2010, 579 claims were accepted in 533 cases.

Table 8 **Asbestos compensation from the Asbestos Fund, 1 April 2007 - 31 December 2010**

| Claimant status | No. of pension awards | No. of lump sum awards | Number of accepted claims (award of pension + award of lump sum) | No. of recognized cases | Number of women |
|---|---|---|---|---|---|
| Employee | 520 | 19 | 539 | 501 | 12 |
| Public sector | 4 | 0 | 4 | 3 | 0 |
| Belgian army | 2 | 0 | 2 | 2 | 0 |
| Local and provincial authorities | 11 | 0 | 11 | 10 | 1 |
| SNCB | 3 | 0 | 3 | 3 | 0 |
| Self-employed | 3 | 0 | 3 | 3 | 0 |
| Other | 9 | 8 | 17 | 11 | 0 |
| **Grand Total** | **552** | **27** | **579** | **533** | **13** |

Source : FMP

That adds up to 552 pension awards and 27 lump sum awards for 533 cases recognized under the Asbestos Fund.

The number of pension awards differs from the number of recognized cases as some cases may result in multiple accepted claims following a review of the disability rate. Also, a pension award decision may be followed by a lump sum award decision in the same case. Women account for about 2.5% of all asbestosis cases in which the Asbestos Fund has made a payout.

**39.** Institut national du cancer (2011) *Amiante et mésotheliome pleural malin,* Boulogne-Billancourt.

# Section 3
# The occupational disease and working conditions survey data compared

The data in the previous section could superficially be taken as showing that women in Belgium enjoy particularly favourable working conditions.

The only exceptions would appear to be three risk groups:
— Dermatological risks: group 1.2 skin diseases alone account for 45% of all the diseases for which women were compensated in 2009 for a permanent work disability in the private sector under the list system (1951 cases out of 4332)[40];
— Biological risks (a total of 168 cases of infectious or parasitic diseases);
— natural latex-related allergy risks (318 cases).

The specific prevalence of the latter two categories among women is due to the very high female employment rates in the health care sector, whereas the importance of the first group is probably more indicative of the biases introduced in the social construction of occupational diseases.

Women much more than men fall within a very small number of occupational disease tables in the prescribed list. Men are compensated for a much wider range of diseases. And whilst it is true that two groups of specific diseases - musculoskeletal disorders and back injuries caused by mechanical vibrations and silicosis – are more prominent among men, these tables essentially reflect history. There are very few new cases of silicosis. The list codes on mechanical vibration-induced conditions have been modified and the new criteria laid down make it harder to get recognition of an occupational disease.

It is as if the list were describing – incompletely, of course - a mixed bag of health impairments in men, and as if women were included only as an exception for the odd highly specific disease simply in order that they should not be completely excluded from the system. Men have cancers, respiratory diseases, hearing damage, musculoskeletal disorders, skin diseases, etc. Women would appear to be concentrated in a very small number of specific diseases.

The very high prevalence of skin diseases among women suggests that the hazards of work become more visible only when they affect the outer surface of their bodies. To put it bluntly, women's main worth appears to be skin-deep.

**40.** For men, this group accounts for only 3.3% of diseases.

The way women's work is perceived is apt to minimize the risks, to trivialize a combination of factors as being those of "ordinary life": repetitive work, tiring or painful positions, monotonous work, exposure to hazardous chemicals in what are considered ancillary or peripheral activities (cleaning, packaging, etc.). The relative risk that wage labour entails for women's health is perceived to be significantly less than for men, even where the data are adjusted for working time and length of working life.

Such a naïve interpretation is belied by many facts. The sharp drop in female employment rates after the age of fifty suggests that work -induced burnout plays a considerable role. Insofar as the reporting and recognition of an occupational disease can take place even after stopping work, withdrawal from the labour market due to job burnout should be reflected by an occupational diseases tracking system.

What needs to be analyzed is the social construction of occupational diseases. The diseases most common among or specific to women workers are those that get pushed into the background.

This section will refer to two main information sources:
— the data from the Dublin Foundation's European Working Conditions Survey[41];
— selected workplace health data from European countries or from comparative studies in Europe.

The lack of a national working conditions survey is obviously a big limitation. Ironically, Belgium - one of the first industrialized countries in continental Europe – has much catching-up to do in the collection and analysis of data on working conditions and their health impact – a lag compounded by the fact that public health surveys pay almost no attention to working conditions.

## The European Working Conditions Survey (EWCS)

The EWCS has been carried out by the Dublin Foundation at five-year intervals since 1990. It is a perception survey that collects a fairly huge body of data on the conditions of paid work, some very summary data on unpaid work, and health data, along with a certain amount of data on employment conditions.

The questionnaire has changed between 1990 and 2010, meaning that trends over time cannot be equally charted for all questions.

The 2010 survey is of particular interest for Belgium in that the regular sample was increased fourfold, giving a more robust statistical sample. Specific analyses of derived data are planned for Belgium. At the time of writing, they were

**41.** Referred to hereafter by its acronym: EWCS.

not yet available. The data used are those already published by the Dublin Foundation. The analysis of these is therefore limited by the inability to do a more detailed analysis by cross-tabulating multiple variables.

## Basic EWCS data on women's work in Belgium

### Physical agents

On exposure to physical agents, the European survey confirms most national data indicating a higher prevalence of such exposures for men. However, the gender gap does not by itself explain the - much wider – gap in recognition of occupational diseases.

Just two examples will be considered here:

1. **Noise**: the EWCS' finding is that the percentage of women who are exposed to loud noise for at least a quarter of their working time is about half the percentage of men, and this ratio has not significantly changed in almost twenty years. But where recognition of occupational diseases is concerned, women account for less than 1% of new cases of deafness or hearing loss recognized in 2009;
2. **Vibrations**: the prevalence of exposure ranges from a little over one sixth (in 1995) to just over a quarter (in 2010). For the recognition of occupational diseases, the proportion of women is significantly lower. Women account for no more than just under 0.5% of all recognized cases.

### Work organization and musculoskeletal disorders

The EWCS data on work organization do not enable a direct correlation to be made with specific diseases. However, some do underscore that some working conditions are big factors in the development of musculoskeletal disorders. There is a close correlation between the prevalence of musculoskeletal disorders and a set of characteristics of work organization and working conditions.

Different classifications of musculoskeletal disorders can be proposed. The synopsis given here essentially follows the categorisation used by the European Agency for Safety and Health at Work.

Work-related MSDs cover a broad range of inflammatory and degenerative diseases of the locomotor apparatus, including:

— inflammation of tendons (tendinitis and tenosynovitis), especially in the forearm and wrist, elbow and shoulders, usually related to repetitive work and prolonged positions;
— myalgia, i.e., pains and functional disorders of the muscles occurring primarily in the region of the neck and shoulders, also related to static postures;
— nerve compression, occurring in the wrist and forearm in particular (mainly carpal tunnel syndrome);

— degenerative diseases of the spinal column, generally in the nape of the neck and the lumbar region, particularly related to the manual handling of loads or hard physical labour. This can also result in osteoarthritis of the hip or knees.

These disorders are chronic and multifactorial. There is an interaction between ergonomic factors, and psychological factors. Stress is a factor in the development of MSDs. The symptoms tend only to appear after prolonged exposure to work-related risk factors like postural constraints, monotonous and repetitive tasks, and other factors that generally stem from working conditions.

## MSD risk factors

Data from other countries suggest that women are highly exposed to the risk of MSDs. The data for Belgium from the EWCS survey confirm this trend.

Heavy lifting is predominantly a male risk (almost 40%), although not insignificant for women (more than a fifth of women workers are exposed to this risk). By contrast, lifting or moving people is primarily done by women (about one female worker in six).

Table 9 **Does your job involve lifting or moving people? Positive responses in Belgium for at least a quarter of working time (%)**

| | 2005 | 2010 |
|---|---|---|
| Male | 8.1 | 6.1 |
| Female | 14.0 | 15.7 |
| **All** | **10.7** | **10.4** |

Source: EWCS

Table 10 **Does your job involve carrying or moving heavy loads? Positive responses in Belgium for at least a quarter of working time (%)**

| | 1991 | 1995 | 2000 | 2005 | 2010 |
|---|---|---|---|---|---|
| Male | 27.9 | 35.8 | 33.8 | 35.5 | 39.2 |
| Female | 23.6 | 25.7 | 30.1 | 24.4 | 22.9 |
| **All** | **26.2** | **31.7** | **32.2** | **30.7** | **31.9** |

Source: EWCS

Nearly 40% of workers perform repetitive work, which has significantly increased in the last fifteen years (an approximately 10% rise in the total share of exposed workers). This increase affects both women and men to broadly similar extents.

Table 11 **Does your job involve repetitive hand or arm movements almost all of the time? Positive responses in Belgium (%)**

| | 1995 | 2000 | 2005 | 2010 |
|---|---|---|---|---|
| Male | 26.3 | 26.7 | 27.8 | 36.9 |
| Female | 30.9 | 27.8 | 30.7 | 40.1 |
| **Total** | **28.2** | **27.2** | **29.1** | **38.4** |

Source: EWCS

## Recognition of MSDs as occupational diseases in Belgium

Vibration-related low back disorders have already been considered. Vibrations aside, MSDs are currently found in only a handful of prescribed disease codes (list system) (couched in vague terms that prevent all MSDs from being safely grouped together).

Code 1.605.03 deals with a number of low back disorders for which exposure to mechanical vibration is not required. Of a total of 956 cases for which compensation for permanent work disability was awarded in 2009 in the private sector, women accounted for just over 2% (22 cases). The scope for getting recognition of a low back disorder is extremely small even in the open system. Load-carrying is not considered by current regulations and the FMP's medical and administrative practices to be a work-related cause of low back disorders.

Compensation for low back pain as an occupational disease has already been extensively discussed within the Fund. The current situation is blocked on the basis of a questionable compromise. The Fund is involved in "secondary prevention" programmes for "workers with low back pain" and acknowledges the role of working conditions in the development of these diseases by providing ergonomic expertise, but refuses to compensate them as occupational diseases (apart from of some very narrowly-defined prescribed diseases and the very occasional case considered in the open system). In 2009, three cases of bone, joint or intervertebral disk disease were recognized as occupational diseases in the open system. All concerned men. Most of those concerned by the "workers with low back pain" prevention programmes are women (367 cases out of 631 in 2009).

Code 1.606.11 deals with disorders of the periarticular sacs, for which 359 people were compensated for permanent work disability in 2009 – all male.

Code 1.606.21 is for a group of diseases consisting primarily of tendinitis. The total number of compensated cases is very small: 12 women and 11 men. The reason is simple: these conditions are recognized only for performing artists! All other occupational categories have to run the obstacle course of the open system.

Code 1.606.51 covers damage to the nerve function due to pressure. However, the recognition criteria are highly restrictive and exclude most cases of carpal

tunnel syndrome. In 2009, 470 people with an occupational disease gained recognition under this code. Women accounted for just over a quarter of that total (134 cases).

Adding together the different list codes that do not involve mechanical vibrations yields a total of 1808 cases of permanent work disability recognized in 2009 in the private sector for diseases associated with MSDs. Women make up just over 9% of this total (168 cases).

Table 12 **Permanent disability recognized in 2009 (private sector) for MSD-associated conditions (excluding mechanical vibrations)**

| | Men | Women | Total |
|---|---|---|---|
| Code 1.605.03 | 934 | 22 | 956 |
| Code 1.606.11 | 359 | 0 | 359 |
| Code 1.606.21 | 11 | 12 | 23 |
| Code 1.606.51 | 336 | 134 | 470 |
| **Total** | **1640** | **168** | **1808** |

Source: FMP

For the open system, the situation is as follows. The accepted claims relate to four groups of MSD-associated diseases:

1. Group C - carpal tunnel syndrome. Recognized cases are extremely rare. No new cases were recognized in 2009 or 2008. In all, a total of 2 people received permanent disability awards in 2009, both men;
2. Low back disorders present no better a picture. A single case awarded compensation in 2009. A man, need it be said?;
3. Bone, joint, intervertebral disk disorders - three recognized new cases of permanent work disability in 2009 (all men). Compensation was paid out for a total of 184 cases. Women accounted for 20% of the total with 38 cases. It is more than probable that a health survey in any large hospital would identify a higher number of cases;
4. Tendinitis was recognized in 19 new cases in 2009 (16 men and 3 women) in the private sector and local and provincial authorities. The total number of people compensated for that year amounted to 359, of whom 108 were women (30%).

Aggregating all the cases recognized in the open system for MSD-associated conditions gives a total of 546 cases, of which 146 women (about 27% of the total).

Both the absolute numbers and percentages of women are extremely low when compared to other European countries. For France in 2007 all occupational categories combined, for example, women had a higher likelihood of incurring an MSD risk than men. Table 13 shows that women secured recognition for an average 10 million work hours of a permanent work disability rate of 57.7 (severity index) with an MSD frequency rate of 15.7% versus 42.2 (severity index) and a frequency rate of 8.6 respectively for men. As can be seen, occupational category is anything but non-discriminatory as women manual

workers – whose work often consists of repetitive tasks in harsh working conditions - secured recognition of an average MSD frequency rate of 65.6%.

Table 13 **MSD risk indicators by occupational category and sex (2007)***

| Occupational category | Frequency rate per 100 workers | | |
|---|---|---|---|
| | Men | Women | Total |
| Managers and business owners | 0.3 | 1.0 | 0.5 |
| Associate professionals | 0.7 | 2.2 | 1.3 |
| Non-manual employees | 3.8 | 11.9 | 9.7 |
| Manual workers | 16.5 | 65.6 | 24.8 |
| **Total** | **8.6** | **15.7** | **11.5** |
| Severity index | 42.2 | 57.7 | 48.6 |

* General social security scheme data on workers

Source: DARES Analyses, September 2010, No. 056

The trends over time also clearly portray a vastly different situation in France.

Table 14 **Number of MSDs recognized and compensated in France – 2005-2009**

| Table | Heading | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|
| 57 | Periarticular disorders | 28 278 | 29 379 | 30 968 | 33 682 | 37 728 |
| 69 | Conditions caused by the vibration of certain machines | 182 | 161 | 154 | 157 | 162 |
| 79 | Chronic lesions of the meniscus | 299 | 316 | 360 | 372 | 363 |
| 98 | Chronic conditions of the lumbar spine (heavy loads) | 2260 | 2251 | 2406 | 2338 | 2485 |
| 97 | Chronic conditions of the lumbar spine (vibrations) | 422 | 411 | 392 | 377 | 387 |
| **Total** | | **31 441** | **32 518** | **34 280** | **36 926** | **41 125** |

Source: DARES Analyses, September 2010, No. 056

Also, the French epidemiological surveillance programme for musculoskeletal disorders run in the Pays de la Loire region (pilot network) clearly confirmed that work-related MSDs are being under-reported, as well as the extent of their incidence and prevalence in the workforce[42]. This can be shown for carpal tunnel syndrome in women through two tables.

**42.** The programme, which is focused on MSDs, combines three activities: the monitoring of sentinel health events in the general population (e.g., carpal tunnel for upper limb MSDs); assessment of the prevalence of the main upper limb MSDs and their work-related risk factors; and registration of reported MSDs as compensable occupational diseases. It was set up by the French Institut de veille sanitaire (Healthwatch Institute) in partnership with the Laboratory of Ergonomics and Occupational Health at the University of Angers.

Table 15 **Prevalence of the main upper limb MSDs (Pays de la Loire network - France, 2002-2004) (%)**

| Type of MSD | Women | Men | Total |
|---|---|---|---|
| Rotator cuff syndrome | 8.5 | 6.6 | 7.4 |
| Carpal tunnel syndrome | 4.0 | 2.4 | 2.4 |
| Lateral epicondylitis | 2.5 | 2.4 | 2.4 |
| Cubital tunnel syndrome | 0.9 | 0.7 | 0.8 |
| Extensor/flexor tendinitis of the fingers and wrists | 0.6 | 0.9 | 0.8 |
| De Quervain's disease (tenosynovitis) | 2.1 | 0.6 | 1.2 |
| At least one of the six main MSDs | 14.8 | 11.2 | 12.7 |

Source: *La santé des femmes en France*, 2009: 265

Table 16 **Population attributable fractions of risk (FRAE) for occupations with an excess risk of carpal tunnel syndrome in women (France) (%)**

| Occupations | FRAE |
|---|---|
| **Non-manual employees** | 16 |
| Sales staff (sales assistants, check-out operators) | 46 |
| Personal services workers (waiting staff, hospitality workers, hairdressers, child minders, cleaners) | 29 |
| Civil service workers (office workers, hospital assistants, nursing assistants) | 23 |
| **Manual workers** | 58 |
| Unskilled industrial workers (food, electricity and electronics, leather) | 69 |
| Agricultural workers (wine-growing, fruit growing, etc.). | 74 |
| Craft-type unskilled workers (cleaners) | 50 |

Source: *La santé des femmes en France*, 2009: 265

## The overall health impact

It could be concluded from the occupational disease statistics that prevention has made great strides forward and that this has significantly reduced the overall harm that work does to health. This starry-eyed view is contradicted by the EWCS findings for Belgium.

The overall health impact of work is measured in the European survey by three key indicators. Two focus on the worker's immediate perception of the health damage done by his working conditions. The third concerns the expected long-term effects of those conditions. Workers are asked whether they think they will be able to do the same job when they are 60 years old. The Belgian data fall within the general trend evidenced for the different European countries. The immediate impact of paid work on women's health is generally less adverse than for men. The delayed impact over time is generally as if not more adverse.

Table 17 **Do you think your health or safety is at risk because of your work: Positive responses in Belgium (%)**

| | 1991 | 1995 | 2000 | 2005 | 2010 |
|---|---|---|---|---|---|
| Men | 23 | 22.7 | 27.8 | 26.9 | 24.7 |
| Women | 11.4 | 14.9 | 24.9 | 20.1 | 18.9 |
| **Total** | **18.4** | **19.6** | **26.5** | **23.9** | **22.1** |

Source: EWCS

Compared to the EU-12, the percentages are slightly more favourable for men in Belgium, but less favourable for women (approximately 2% difference). The trend over time shows a slight slippage for men and a sharp decline for women.

A second question, partly overlapping the first, focuses more closely on the perceived health impact of work (not including safety). As re-worded for the 2010 survey, it also allows for a positive perceived impact.

Table 18 **Does your work affect your health, or not? Findings of the 2010 survey in Belgium (%)**

| | Yes, mainly positively | Yes, mainly negatively | No |
|---|---|---|---|
| Men | 9.5 | 24 | 66.6 |
| Women | 9.3 | 18 | 72.7 |
| **Total** | **9.4** | **21.3** | **69.3** |

Source: EWCS

The third question on the prospect of being able to do the same job when the worker reaches 60 yields particularly telling findings. They suggest that the long-term impact of working conditions is worse for women. These data are borne out by a good part of the literature highlighting that more women workers are affected by job burnout.

Table 19 **Do you think you will be able to do the same job you are doing now when you are 60 years old? Answers in Belgium (%)**

| | 2000 | | | 2005 | | | 2010 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Yes, I think so | I wouldn't want to | No, I don't think so | Yes, I think so | I wouldn't want to | No, I don't think so | Yes, I think so | I wouldn't want to | No, I don't think so |
| Men | 52.7 | 11.8 | 35.5 | 54.4 | 9.6 | 36.0 | 59.6 | 15.6 | 24.8 |
| Women | 48.4 | 13.5 | 38.1 | 49.7 | 13.5 | 36.8 | 54.2 | 17.1 | 28.6 |
| **Total** | **50.9** | **12.5** | **36.6** | **52.3** | **11.3** | **36.4** | **57.1** | **16.3** | **26.6** |

Source: EWCS

A new question introduced into the 2010 European survey focuses on presenteeism, i.e., the fact of going to work even though ill.

Table 20 **Over the past twelve months did you work when you were sick? Answers in Belgium (%)**

| | Yes |
|---|---|
| Men | 45.7 |
| Women | 50.9 |
| **Total** | **48** |

Source: EWCS

The replies for Belgium point to this being a widespread problem and more prevalent among women than men.

# Section 4
# Research recommendations

Any exploratory report gives the sense of a job half done. Many questions have been left unanswered and could not be addressed within the limits of what one person can accomplish in a short time. This section makes a number of proposals for research. They are far from complete, and the concern has been more practical than theoretical, aimed at identifying evident gaps in knowledge generation such that the lines of inquiry suggested can prompt the adoption of policies that create linkages between occupational health protection, an egalitarian operation of social security, and the broader goals of equality in society.

## The medium and long-term impact of occupational diseases (and work accidents) on employment

Table 21 **Employment rates in the 55-64 age group in Belgium (%)**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Men | 41.7 | 40.9 | 42.9 | 42.8 | 42.9 |
| Women | 22.1 | 23.2 | 26.0 | 26.3 | 27.7 |
| **Total** | **31.8** | **32.0** | **34.4** | **34.5** | **35.3** |

Source: Federal Ministry - Employment, Labour and Social Dialogue

The employment rate of women aged 55-64 is particularly low. In 2009, it was approximately one-third that of women aged 25-54, while for men the proportion is closer to half. The build-up of health damage throughout working life is apt to create a process of job burnout that may play into this.

It would be of interest to determine from the data in Belgium's central social security database to what extent women with a recognized occupational disease manage to hold on to their jobs. I would surmise that insufficient attention to prevention policy may act to exclude women from the job market on a much bigger scale than men. This conjecture is based primarily on research done in Italy on the post-accident careers of work accident victims (Anmil, 2003). The quantitative study could be supplemented by a qualitative survey based on interviews with people with occupational health problems. In order to have a sufficient sample for the quantitative survey, joint research should preferably be carried out on all women awarded compensation for an occupational risk, including women with a recognized permanent disability from a work accident.

## Cancer and work: a largely unexplored field of research on working conditions in Belgium

Throughout this research, it became clear that the available data on the link between cancer and work in Belgium were singularly limited and fragmented compared to those available in other countries. The last attempt to estimate the percentage of workers exposed to carcinogens in Belgium was for the period 1990-1993[43] in an application of the European Carex[44] project to Belgium, which estimated something over 900,000 cases of occupational exposure to carcinogens for a total of about 700,000 exposed workers (21% of the total). One limitation of the Carex project estimates is that they are not gender-differentiated and generally rely on the available epidemiological literature which tends to under-assign a large share of workplace exposures in female cancers.

Poor data makes for poor prevention. While the regulations require that workers exposed to carcinogens should undergo health surveillance, there is no consolidated data on the number of workers exposed, the actual conditions of exposure or the follow-up of these workers' health. The findings of the Sumer survey[45] done among occupational doctors is that 13.5% of workers in France are exposed to carcinogens: 20.4% men and 4.3% women[46]. The methodology and criteria used differ from those of the European Carex survey, which prevents comparison of results[47].

The percentage of exposed workers in Belgium is likely to be roughly the same as in France. The number of cancers compensated as occupational diseases remains very low. Year over year, it can vary between 110 and 220 cases. Cancers recognized tend to be concentrated on those induced by asbestos exposure. Based on data published by Eurogip (2010), the number of cancers for which compensation is awarded as occupational diseases caused by a non-asbestos exposure stands at around thirty cases a year[48].

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**43.** Kauppinen *et al.,* 1998.

**44.** Carex (Carcinogen Exposure) is an international database that compiles information on 139 carcinogens by country and industry.

**45.** The Sumer surveys are medical surveillance surveys of occupational exposures done in France, coordinated by the Department for Coordination of Research, Studies and Statistics (DARES) and the Occupational Health Inspectorate of the Ministry of Labour, Employment and Health.

**46.** Guignon & Sandretti, 2005 a and b.

**47.** The main differences between the exposures looked at by Carex and Sumer respectively concern tobacco smoke and sunlight, which were included in Carex but not evaluated in Sumer. As to methodology, Sumer is probably more precise than Carex: it is an interview-based survey done by occupational doctors among a representative, extended sample, whereas Carex is based on estimates from the epidemiological literature to build a job-exposure matrices system applied to employment data from the different countries covered.

**48.** I am unaware of any cancer having been recognized under the open system. Based on the list, cancers not induced by asbestos exposure concern only a small number of anatomical sites **and** a small number of causative agents. Only cancers of the upper respiratory tract (sinuses and nasal cavity) caused by wood dust exceed 10 units per year.

The FMP publishes no precise figures on women's share of recognized cancer cases. The FMP's Karim Wilmotte was kind enough to perform such calculations for this survey. The results are shown in the table below.

Table 22 **Cancers recognized as occupational diseases, 2001-2010**

| | Men | Women | Total | Pleural and peritoneal mesotheliomas (of which women) |
|---|---|---|---|---|
| 2001 | 108 | 2 | 110 | 58 (0) |
| 2002 | 139 | 3 | 142 | 72 (0) |
| 2003 | 158 | 2 | 160 | 84 (0) |
| 2004 | 133 | 2 | 135 | 60* (0) |
| 2005 | 166 | 4 | 170 | 97 (4) |
| 2006 | 171 | 4 | 175 | 102 (3) |
| 2007 | 163 | 1 | 164 | 91 (0) |
| 2008 | 206 | 6 | 212 | 128 (6) |
| 2009 | 191 | 4 | 195 | 105 (4) |
| 2010 | 150 | 4 | 154 | 81 (0) |
| **Total 2001-2010** | **1585** | **32** | **1617** | **878 (17)** |

* In 2004, in addition to the 60 cases identified as "mesothelioma" or "pleural mesothelioma", 12 cases were identified as "malignant tumour of the heart, mediastinum and pleura." / Source: FMP

Women account for approximately 2% of all cancers recognized as occupational diseases. Mesotheliomas account for about 54% of all recognized cases. Women represent about 2% of mesothelioma cases.

The number of new cancer cases in Belgium stands at approximately 50 000-60 000 per year. This means that the percentage of cancers recognized as occupational diseases is between just over 0.2% and just under 0.4% of all cases on an annual basis. There are slightly more than 30 000 cancers among men and slightly more than 25 000 cancers among women. Taking an approximate average of 150 cancers a year reported as occupational diseases among men, that is equivalent to about 0.5% of cases. For women, the percentage is about 0.1% of cases.

A project run in France since 2002 in the Seine-Saint-Denis *département* provides interesting evidence that the role of working conditions in women's cancers may be seriously underestimated. The project is based on interviews to recreate the work histories of cancer patients treated in three hospitals in the area. It identifies exposures to carcinogens that have occurred throughout their past working life and if the conditions appear to be met, enables a claim to be put in to get recognition as an occupational disease. 60% of women whose work histories were recreated had been exposed to one or more carcinogens during their work (Thébaud-Mony, 2006).

A similar survey methodology would have particular relevance to female cancers. It is worth mentioning that not a single case of breast cancer has ever been recognized as an occupational disease in Belgium notwithstanding the research that points to a link between working conditions (some chemicals

and night work) and such cancers. As far as I am aware, only Denmark in Europe recognizes breast cancer as an occupational disease subject to conditions.

## Legal and sociological analysis of the processes for recognition of occupational diseases

Recognition of a disease is a multi-participant process. The affected person, possibly their entitled beneficiaries, and the staff of the Occupational Diseases Fund are involved in all cases. Medical reports may be required; the quality of the data compiled by preventive services may be critical in establishing the conditions of exposure. Legal cases may be brought before the courts. All these processes involve an interplay of legal and medical criteria. Causality, presumption and probability are not clear-cut concepts. To the best of my knowledge, legal and sociological research have largely neglected this area, and the gender dimension of criteria even more so[49]. A critical review of the FMP's administrative procedures and the case law could arguably give more insight into how the perception of occupational diseases is shaped and why they are shaped in a way so adverse to women.

## Increasing knowledge about the impact of working conditions on women's health

A number of things need to be done to improve understanding of the impact of working conditions on women's health.

Processing the data for Belgium yielded by the Dublin Foundation's working conditions survey is clearly an opportunity not to be missed.

Analyses of derived data should also be done on the basis of the Health Survey in Belgium[50] and in particular to identify gaps in it regarding working conditions so as to develop a section on "working conditions" in the next survey.

**49.** The most systematic body of work comes from North America, especially, Quebec. In Europe Probst (2009) has studied the gender dimension of the recognition of musculoskeletal disorders in Switzerland.

**50.** This survey looks at the health of Belgians and how their health problems impact their daily lives. It also sets out to look at the use of different health care services, preventive medicine and medication use, and to identify how much access different socioeconomic groups have to them. More information on https://www.wiv-isp.be/epidemio/epifr/index4.htm

# Section 5
# Selected policy recommendations

Numerous policy recommendations could be made on the basis of what this report reveals. Some expressly involve mainstreaming gender equality across occupational health policies, especially the prevention and compensation of work-induced diseases. Others show how much a gender analysis paves the way for a critical review of all institutional provision by formulating policy criteria to help them deliver the values they are meant to embody more consistently and efficiently.

## Assess and reform the current system for recognition of occupational diseases

Taken overall, this report suggests that the current system for recognition of occupational diseases is increasingly unfitted to changing working conditions. The basic principles of the legislation remain relevant and justify keeping a specific branch of social security, but the sub-delegation system from Parliament to the Executive and from the Executive to the FMP Management Committee has ended up entrenching conservatism in the management of the system. The drive to make savings seems to have become an end in itself.

Let it be said, however, that these savings are more apparent than real for two reasons:

1. Most of the costs are borne by the health care and benefits branch of social security. Because the Belgian social security system is block funding-based, shifting expenditure between branches merely papers over the cracks;
2. The scant attention paid to occupational health problems effectively reduces the focus on prevention. The chances are that the medium- and long-term costs of a lack of preventive efforts act to push up social security spending – not just on health care and compensation for work disability, but probably also invalidity, different types of early retirement (or phased end of working life) provision and unemployment benefit.

There has been no substantive parliamentary debate on the system as a whole since 1963. Gender inequalities are revealing it to be increasingly unfit for purpose. The list of occupational diseases needs to be expanded. The open system needs to be reorganized to allow the burden of proof to be shifted where epidemiological data point to a higher prevalence of certain diseases in certain sectors or occupations. The obligation to report occupational diseases should be extended to the entire medical profession.

Reform is arguably particularly pressing for three groups of medical conditions: cancers, musculoskeletal disorders and psychosocial factor-related illnesses.

## Get the link between recognition of occupational diseases and prevention working

The current system is holding back prevention in several respects:

1. The highly restrictive conditions laid down in Section 51 of the Restated Occupational Diseases Acts which prevent employers from being sued create a system of exceptions that cannot be justified in present conditions. Belgium is the only European country to have preserved such strict immunity from civil liability for employers. Being able to sue under the ordinary law of negligence would improve the situation of victims (full compensation for loss instead of lump sum compensation) and reduce social security spending (through subrogation proceedings that would enable the FMP to recover the amounts paid from the employer at fault). Above all, it would be a big incentive for preventive efforts. In the past, various private members' bills attempting to change this aspect of the legislation have failed, due not least to opposition from the National Labour Council. While the employers may be understandably resistant to reform, trade union objections[51] are based on equating of the status of workers and employers in a way that does not add up. Challenging the civil law immunity of employers does not mean changing the rules of workers' civil liability. The employer's powers over the organization of work justify the existence of different sets of rules;
2. Labour inspection to investigate the factors involved in the onset of long-development-time diseases remains very limited. Increasing inspectorate resources, particularly for occupational health, is an absolute prerequisite for any improvement. More systematic use of formal action and penalties would further underscore that occupational health is not optional, that firms must meet the standards required by government, society and workers;
3. There is a big issue around setting up bodies to disseminate workplace-derived data. Much information exists, but it is piecemeal. Many positive experiences with prevention are to be found in workplaces. Specialists in different areas of health and safety take action daily. The lack of a national information and research institute is definitely one of the big weaknesses of the prevention system in Belgium.

## Gender balance: a health and safety at work policy objective

At present, gender equality and health and safety policies are separated by an impenetrable barrier. The various stakeholders need to consider that access to all jobs for women and men alike requires a significant improvement

51. The trade unions are not unanimous on this point - the main industry federation of the socialist trade union confederation FGTB is in favour of legislative reform.

in working conditions. Gender segregation acts to undermine prevention by "naturalizing" a number of risks under cover of stereotypes of masculinity or femininity. Awareness-raising campaigns therefore need to be run towards all those involved in occupational health to treat gender balance as a goal. All risk assessments should consider whether a specific job can be accessed by both women and men in non-health-impairing conditions.

Positive synergies could be created in workplaces between the remits of Works Councils (WCs) and Prevention and Protection at Work Committees (CPPTs) to support policies delivering the aims of gender equality and health at work.

The formulation of a new Belgian strategy for health and safety at work[52] could be the opportunity for such a policy shift.

**52.** The current strategy runs from 2008 to 2012.

# Conclusions

In 2001, the Council for the Equality of Women and Men adopted its Opinion No. 45 giving a gender analysis of the health impact of working conditions. It made a number of recommendations for tackling discrimination in this area, most of which have not been acted on.

Almost ten years on, the data on reporting and recognition of occupational diseases are still showing a significant under-representation of women which seems not to be justified by objective circumstances of their working conditions.

An analysis and comparison of FMP data with the data on working conditions support the assumption of systemic discrimination against women – "systemic" in the sense that it results from a combination of factors that are not gender discriminative but which contribute to increase the social, political and institutional invisibility of the risks of work for women. Some of these factors lie upstream of the occupational diseases recognition system. The very criteria of occupational segregation and the lower value placed on women's work play an important role. The gaps in health at work legislation, under-resourcing of enforcement, the focus on accidents over diseases, and under-performing preventive services are other factors. Also, the lack of crossover between the three policy areas - occupational health, gender equality and public health – adds to the difficulty of giving coherent consideration to working conditions in the overall generation of inequalities. While there is a large body of excellent literature on pay inequalities, the issue of gender balance in working conditions seems to be relegated to the background or confined to training and job classification considerations.

The many upstream factors play into specific defects in the system for reporting and compensation of occupational diseases. The list of recognized diseases reflects male jobs in traditional industries more than the reality of work today. The recognition criteria play against those with an irregular or unstable career (job insecurity). Little allowance is made for "peripheral" jobs like cleaning, packing and packaging, maintenance and storage. Psychosocial risk-related health problems tend to be ignored and the recognition of musculoskeletal disorders remains a problem. Epidemiological studies on cancers pay scant attention to women.

The multifarious factors highlighted by this analysis must not be used as an excuse for doing nothing on the grounds that too many reforms would be

required involving too many different stakeholders. Likewise, the gaps in the data or research must not become excuses for not changing right now what can be clearly identified as factors of discrimination. Even limited improvements could well help to create a dynamic for challenge and change. It would be dangerous to wait for a perfect and complete action plan to be developed. A critical review of the list of occupational diseases from a gender perspective and improving the opportunities that the open system should offer are two important links in the chain. Although not enough to eliminate discrimination, they could help reduce it if accompanied by a policy debate and extended by the unions.

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# List of tables

# Annex 1
# List of recognized occupational diseases (at January 2010)

| | |
|---|---|
| **Group 1.1** | **Occupational diseases caused by (named) chemical agents** |
| **Group 1.2** | **Occupational skin diseases caused by substances and agents not elsewhere classified** |
| **Group 1.3** | **Occupational diseases caused by inhalation of substances and agents not elsewhere classified** |
| **Group 1.4** | **Infectious and parasitic occupational diseases** |
| **Group 1.6** | **Occupational diseases caused by physical agents** |
| **Group 1.7** | **Occupational diseases that cannot be classified in another category** |

The complete list in French, Dutch and German is on the Occupational Diseases Fund website: http://www.fmp-fbz.fgov.be/fr/listes_fr01.htm

# Annex 2
# Disease groups in the FMP statistics

| | |
|---|---|
| A | Deafness |
| B | Haematopoietic system |
| C | Carpal tunnel |
| D. | Skin diseases |
| E | Mainly tear overuse of the spinous processes |
| H | Viral hepatitis |
| L | Low back disorders |
| M | Osteoarticular complaints of the upper limbs |
| N | Ear-nose-throat diseases other than deafness |
| R | Respiratory system |
| S | Bone, joint and intervertebral disk diseases |
| T | Tendinitis |
| U | Diseases of the periarticular sacs |
| V | Vascular disease |
| X | General illness (infectious, kidney, nerve disease, diseases not elsewhere classified) |
| Y | Eye disorders |

# Annex 3
# **Recommendations**

| Acronyms used in the recommendations | |
|---|---|
| FPS ELSD | Federal Ministry - Employment, Labour and Social Dialogue |
| FPS PH | Federal Ministry - Public Health |
| IEFH | Institute for the Equality of Women and Men |
| SEPP | External Prevention and Protection at Work Services |
| SIPP | Internal Prevention and Protection at Work Services |
| CPPT | Prevention and Protection at Work Committee |
| FMP | Occupational Diseases Fund |
| ISP | Scientific Institute of Public Health |
| BCSS | Social security database office |
| AIM | Intermutualist Agency |

**Recommandation 1**

**Perform a gender analysis of the statistical data from the European Working Conditions Survey (Dublin Foundation)**

**Context**

The Dublin Foundation published the initial results of its fifth survey of changing working conditions in Europe over twenty years in 2011. At the instance of the Federal Ministry - Employment, Labour and Social Dialogue (FPS ELSD) the 2010 sample for Belgium was expanded to 4000 individuals. Unlike many European countries, no regular national survey of working conditions is done in this country. This opportunity should be taken to make best use of the data collected.

**Courses of action**

- The Institute for the Equality of Women and Men and trade unions should press the FPS ELSD to focus on a methodology to develop genderized statistical analyses and develop gender indicators (Act of 12 January 2007, Council for the Equality of Women and Men Opinion No. 123 of 12/06/2009) in processing the "Belgian" component of the survey. In other words, when processing the survey, apply gender as a cross-cutting variable across all other proposed variables in the analysis.
- Repeat the FPS ELSD's initiative at regular intervals to keep working conditions in Belgium nationally under review.
- Check that the sample sectors of activity are representative.
- Promote dissemination of the analysis of the Working Conditions Survey among front-line workers (prevention advisors, occupational doctors) and experts in working conditions (academics, trade unions) to stimulate exchanges and close cooperation on prevention.

**Relevant stakeholders**

FPS ELSD, trade unions, SEPP, SIPP, professional associations of prevention advisors and occupational doctors

**Recommandation 2**

**Extend the Health Survey analyses to extract information linking health, work and exposure to risks**

**Context**

The interview-based Belgian Health Survey done by the Scientific Institute of Public Health (IPH) has been administered four times (1997, 2001, 2004, 2008). Examination of the contents of the different questionnaires and reports is obviously relevant to public health, but also to occupational health, in particular through the topics of health of the general population, subjective health, physical pain, chronic conditions and limitations, mental health and socio-economic inequalities.

In 2002, the Council for the Equality of Women and Men put out a very detailed opinion on the health survey with a view to the 2005 survey (Opinion No. 51 of 13.09.2002 on the 2001 Health Survey) highlighting that "the 1997 and 2001 Belgian Health Surveys were of very little use to the authorities for conducting a health policy designed to reduce inequalities between men and women". It also suggested adding a section on occupational health to the survey. This Opinion is still relevant.

**Courses of action**

- Promote the development of statistical analyses by the ISP not only on the basis of sociodemographic characteristics (age, sex, education level, degree of urbanization of place of residence), but also on the basis of the individual's socio-economic status, occupation and sector of activity they work in to yield data on occupational health (Act of 12/01/2007 and CECHF Opinion No. 123 of 12/06/2009).
- Promote processing of the survey to apply gender as a cross-cutting variable across all other proposed variables in the analysis.
- Add a section on occupational health to the next health survey.

**Relevant stakeholders**

ISP, FPS Public Health

### Recommandation 3

**Further develop identification for prevention of occupational cancers**

**Context**

The available data on the link between cancer and work in Belgium is particularly limited and fragmented compared to those available in other countries. There is no consolidated workplace-derived data disseminated on the number of workers exposed, the actual conditions of exposure or the follow-up of Belgian workers' health. But poor data makes for poor prevention.

The Fondation Registre du Cancer (Cancer Registry Foundation) is a national network that has been systematically collecting data on new cancer cases in Belgium since 2005. It publishes statistics based on an international classification of the affected organs; incidence rates are calculated by age, sex and region.

**Courses of action**

- Improve the Cancer Registry's data collection by including the individual's employment status, and, if relevant, line of work and sector of activity.
- Combine the Cancer Registry data with the data from the BCSS' "Labour market and social protection" Datawarehouse annually.
- Task the Cancer Registry and/or FMP and/or mutual insurance organizations with interviewing a number of people with potentially occupational exposure-induced cancer on their work history (occupational health and prevention watchdog role).
- Promote exchanges of information between and joint work by the FMP and Cancer Registry Foundation (occupational health and prevention watchdog role).
- Promote the dissemination of information and work done to front-line operators (prevention advisors, occupational doctors) and experts in working conditions (academics, trade unions) to foster exchanges and consultations on prevention.

**Relevant stakeholders**

FMP, Cancer Registry Foundation, BCSS, FPS ELSD, FPS SP, SEPP, SIPP, professional associations of prevention advisors and occupational doctors, AIM and mutual insurance organizations

### Recommendation 4

**Conduct in-depth analysis of notifications and compensation of occupational diseases**

**Context**
The FMP publishes an annual report. Most of the statistical information is now disaggregated by gender (except for occupations and industries). To comply with the Council for the Equality of Women and Men Opinions No. 45 and 123, this statistical information should also include a genderized data breakdown enabling a more detailed analysis of gender indicators by type of industry, occupation, job done, work organization and individual risk exposure directed towards occupational health and prevention.

**Courses of action**
- Educate the union representatives on the FMP Management Committee in the need for detailed gender and sector analyses of registered occupational diseases.
- Promote the processing of data collected by the FMP so as to apply gender as a cross-cutting variable across all other proposed variables in the analysis.
- Educate the members of the FMP's Scientific Committee.

**Stakeholders**
FMP

### Recommendation 5

**Perform legal and sociological analyses of the processes of recognition of occupational diseases**

**Context**
To the best of my knowledge, both legal and sociological research have largely neglected this area, and the gender dimension of criteria even more so. A critical review of the FMP's administrative procedures and the case law could arguably give more insight into how the perception of occupational diseases is shaped and why they are shaped in a way so adverse to women.

**Courses of action**
- Educate the union representatives on the FMP Management Committee in the need for a critical review of the FMP's administrative procedures.
- Educate the members of the FMP's Scientific Committee.

**Stakeholders**
FMP

### Recommandation 6

**Develop tools to identify the medium and long-term impact of occupational diseases (work accidents) on employment**

**Context**

The employment rate for women in Belgium between the ages of 55 and 64 is particularly low. In 2009, it represented approximately one third that of women aged 25 to 54, whereas the proportion is about half for men. Accumulated health damage throughout working life is apt to result in job burnout that may be involved in this. It would be relevant to investigate how many women with a recognized occupational disease have managed to keep their jobs.

**Courses of action**

- Combine selected data on occupational diseases with the data from the BCSS' "Labour market and social protection" Datawarehouse to examine the work histories of women with a recognized occupational disease and/or work disability.
- Supplement the quantitative work with qualitative work based on interviews with people with occupational health problems to develop prevention of occupational diseases.

**Relevant stakeholders**

FMP, FAT, BCSS, AIM and mutual insurance organizations, FPS ELSD

**Recommandation 7**

**Bolster the obligation to notify occupational diseases and the creation of a communication book between health professionals to track individuals' career paths (occupation, industry, working conditions)**

**Context**

Occupational doctors have an obligation to report an occupational disease which they have diagnosed or been notified of by another doctor in four cases: it is a prescribed disease; it is not a prescribed disease in Belgium, but is on one of the two Schedules of the European Recommendation; it is a disease that is established or even suspected to have an occupational origin; in the event of a predisposition to one of these diseases or early symptoms of one of these diseases if such diagnosis could affect the employment tenure or pay of the person affected.

At the annual meeting of the Scientific Society on Occupational Medicine (7 May 2011), the FMP reported on a move to suppress the requirement to communicate a copy of the occupational disease notification to the medical inspector in the FPS ELSD's Department of Wellbeing at Work in order to cut red tape. But wellbeing at work and prevention are precisely the FPS ELSD's jurisdiction. This move is therefore arguably inappropriate.

Moreover, research (in progress) financed by the FPS ELSD (2011) has concluded that there is a need to communicate and exchange information about the employment status of individuals between different health professionals: occupational doctor , GP and medical officer.

The obligation to report occupational diseases also applies to the civil service. However, public sector statistics in Belgium remain highly confidential.

**Courses of action**

- Educate stakeholders on the need to spread workplace-derived information around rather than restrict it, so as to promote prevention of occupational diseases.
- Educate workers' representatives in the point of notifying an occupational disease (prevention) independently of recognition and compensation.
- Develop and widely disseminate workplace-derived statistics on trends in occupational diseases in the civil service, federal and regional institutions and public corporations.

**Stakeholders**

Trade unions, FMP, FPS ELSD, SPF SS (Medex, Empreva, etc.), SEPP, SIPP, professional associations of prevention advisors and occupational doctors