Population and social conditions 3/2000/E/n°19

EUROPEAN OCCUPATIONAL DISEASES STATISTICS (EODS)

PHASE 1 METHODOLOGY

Eurostat Unit E3 « Education, Health and Other Social Domains » (Didier DUPRE), DG « Employment and Social Affairs » Unit D5 « Health, Safety and Hygiene at Work », the Members of the Working Group and the Task Force EODS (European Occupational Diseases Statistics), particularly Mr Antti Karjalainen of the Finnish Institute of Occupational Health (FIOH) and Mr Johnny Dyreborg of the National Institute of Occupational Health of Denmark, have provided invaluable support in preparing this document.

The report in Annex C has been prepared by Mr Antti Karjalainen of FIOH on the basis of a questionnaire filled by the representatives of the Member States in the EODS Task Force.

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Foreword

The establishment of European wide comparable data represents an important element in the European Commission's strategy to evaluate the efficiency of Community legislation on Health and Safety at Work. Knowledge of the numbers and frequencies of occupational diseases in the various sectors and occupations provides an important basis for monitoring and prioritising preventive actions at Community level to improve Health and Safety at Work, as underlined by the Council Resolutions 88/C 28/01[1] and 95/C 168/01[2]. However, it has been a moot point as to whether occupational diseases, recognised on the basis of different social security systems, could provide meaningful bases when comparing the risk level for occupational diseases.

The Commission (Eurostat Unit E/3 « Education, Health and other social domains » and Directorate General Employment and Social Affairs Unit D/5 « Health, Safety and Hygiene at Work ») addressed this problem by launching a pilot project on the collection of data on recognised cases in 1995 for 31 items of the European Schedule of Occupational Diseases[3] in the European Union. (European Occupational Diseases Statistics - EODS – Pilot project). The evaluation of this pilot data was carried out by the Finnish Institute of Occupational Health (FIOH)[4]. The report concluded « the evaluation of the EODS pilot data identified many problems of comparability which can be avoided with improvements in the data collection ». Though it stated that « the data on recognised occupational diseases reflect not only the occurrence of such diseases but inevitably also the way in which the concept of an occupational disease has been integrated into the social security systems » it also indicated that « such data can be used in prevention and in the evaluation of the impact of the problem ».

Later on, the Community Statistical Programme 1998-2002 (Council Decision 1999/126/EC[5]), in agreement with the work programme of DG Employment and social affairs (EMPL) on safety, hygiene and health at work (1996-2000), stipulated that « work will concentrate on the continuation of statistical projects on health and safety » and that « consistent series of data will be established to provide the means for the monitoring of health and safety at work and the efficiency of regulation in this field » (Title VIII, p 22-24).

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[1] Council Resolution of 21 December 1987 on safety, hygiene and health at work, that indicates « The Council takes note of the Commission's intention of submitting to it in the near future … (an) harmonisation of statistics on accidents at work and occupational diseases », O.J. C 28 of 03/02/1988.

[2] Council Resolution of 27 March 1995 on the transposition and application of Community social legislation, that calls upon the Commission « to improve, in agreement with the Member States, the data available on occupational diseases », O.J. C 168 of 04/07/1995.

[3] Recommendation of the Commission of 22/05/1990 concerning the adoption of a European Schedule of Occupational Diseases, 90/326/EC, O.J. L160 of 26/06/1990.

[4] Eurostat Working Paper series, Population and social conditions 3/1999/E/n°2 – European Occupational Diseases Statistics : Evaluation of the 1995 Pilot data – Dr Antti Karjalainen and Dr Simon Virtanen. Languages available : DE/EN/ES/FR/IT.

[5] Council Decision 1999/126/EC of 22/12/1998 on the Community statistical programme 1998-2002, O.J. L42 of 16/02/1999.

In this framework, on the basis of the experience from the pilot project and of a detailed disease-specific questionnaire to the Member States, the FIOH made in 1999-2000 a proposal of improved methodology for EODS Phase 1, in a report which is included in Annex C below. The current document is the result of the work of the Commission with the EODS Technical Subcommittee and Working Group of Eurostat from this proposal. This final version was submitted to the Working Group, at its meeting in September 2000, that decided its implementation after consultations with all the national authorities involved in the information system on occupational diseases.

The overall aim of EODS is to obtain gradually harmonised, comparable and reliable data and indicators on occupational diseases in Europe. The launch of EODS Phase 1, in which data will be collected for 2001 onwards in 14 Member States, is the first step of this progressive project.

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Table of contents

Introduction

The current document, including Annexes A and B, constitutes the specifications for the implementation of the Phase 1 of the European Statistics on Occupational Diseases (EODS) from reference year 2001 onwards, adopted by the EODS Working Group during its meeting on 14/09/2000. During this meeting, all Member States decided to implement the EODS Phase 1 statistics from reference year 2001 onwards, except Germany. For its part, Annex C contains the report made by the FIOH, on the basis of which the current EODS Phase 1 methodology has been drawn up. This report also includes the national answers to the detailed disease-specific questionnaire concerning national recognition and data collection practice, used by the FIOH to prepare the methodological proposals. When points in Annex C differ from those in the previous parts of the current document, they refer to proposals that were not considered in the final methodology.

1 Data to be included in the Phase 1 (General inclusion criteria)

The EODS Phase 1 covers incidence data for the reference year (first reference year : 2001) and prevalent cases leading to the death of the victim in the reference year.

Other prevalent non-fatal cases, which have changed status in the reference year, are covered in Phase 1 in an optional pilot way by the Member States that can realise it. Later on, in a further Phase 2, they will be covered on a more systematic way with specifications defined on the basis of the evaluation of the Phase 1 pilot data.

Inclusion criteria for <u>recognised</u> cases:

1. All cases of occupational diseases which are in accordance with the list of disease specific entities and which fulfil the disease specific inclusion criteria in Annex A of this document.

2. The EODS Phase 1 covers prospective (incident) data for the reference period, i.e.; those occupational diseases *recognised* in the year (first reference year : 2001).

   This ***includes*** all cases, which have been recognised as an occupational disease for the *first time* in the year (first year : 2001):

   - as a temporary occupational disease, i.e., cases which were compensated for sick-leave for the *first time* and where no *permanent* degree of disability has been settled during the reference year; it is considered that cases with at least 4 days or more sick leave (> 3days) are more comparable between the various national systems; the “mild temporary diseases” with sick leaves not higher than 3 days are also included in the data but could be excluded to the analysis when necessary (see classification below);

- as a permanent occupational disease, i.e. a permanent degree of disability was assigned for the *first time* in the reference year independent of the level of disability; it is considered that cases with at least 10% or more permanent incapacity are more comparable between the various national systems; the "mild permanent diseases" with degree of incapacity not higher than 9% are also included in the data but could be excluded to the analysis when necessary (see classification below);

- only post-mortem, i.e., in case the person died because of an occupational disease, which was recognised for the *first time* only post-mortem.

This ***excludes*** cases which were finally *not* recognised as an occupational disease, even they were reimbursed for cost under the health at work insurance scheme, e.g., in relation to medical examinations.

3. The EODS Phase 1 covers also prevalent cases previously recognised as temporary or permanent disease, i.e. before the reference year, for which the person died because of the occupational disease during the reference year (first year : 2001).

NOTE! Criteria 1–3 above will provide (a) incident data for all cases recognised for the first time as an occupational disease in the national system (b) incident data for all cases of fatal outcome due to an occupational disease. This data would provide key information on diseases with a progressive nature and a fatal outcome. The collection of the data defined under criteria 1 to 3 is compulsory in Phase 1.

4. Only **in an optional and pilot way only for the Member States wishing so**, the EODS Phase 1 covers also prevalent cases, which have changed status from a temporary to a permanent occupational disease during the reference period. This concerns all those occupational diseases *previously* recognised as temporary diseases, i.e., before the reference year (first year : 2001), which are now settled with a *permanent* degree of disability level.

5. Only **in an optional and pilot way only for the Member States wishing so**, the EODS Phase 1 covers prevalent cases with a permanent disability (those occupational diseases previously recognised with a permanent degree of disability, i.e., before the reference year), where the level of disability has been changed during the reference period (first year : 2001).

NOTE! Criteria 4 and 5 above will provide incident data for all cases with a change in the level of disability (excepted deaths which are already covered by point 3) during the reference year. These data are of a particular interest for diseases with a progressive nature. The collection of these complementary data should be considered as a key issue, in particular for the complete knowledge of occupational diseases. However, criteria 4 and 5 involve high technical difficulties to collect the data in some current national schemes, as well as comparison problems between the various systems. Consequently, they are considered optional in Phase 1 as a pilot collection of data. The analysis of this pilot data **will be considered only as a pilot study** ***to define the definitive specifications of a possible further Phase 2 of the EODS statistics. Consequently it is expected that the Member States which have the possibility to realise it, should already implement criteria 4 and 5 in Phase 1.***

Concerning the definition of the severity of the disease for all inclusion criteria 1 to 5, the Member states raised the problems of the heterogeneity of the data between the various Member States. The same "degree" of incapacity could represent quite different situations and consequences of the disease in two different countries.

For the temporary diseases, the major problems appear for those diseases for which in some countries no sick leave will be considered when in another country they could involve few days off work. This is why, by analogy with the threshold used for accidents at work, the temporary diseases with less than 4 days' absence are considered but are specifically identified as "mild temporary occupational diseases" to exclude them from the analysis when necessary.

Similarly, for the permanent diseases, the mild cases are not covered similarly among the Member States. Moreover, a threshold around 10% of disability is often used (20% for Germany) either as a limit to compensate or not the permanent disease or to distinguish between levels of compensation. Additionally, it is important not to mix cases of temporary occupational diseases with permanent but mild occupational diseases. Consequently, the permanent diseases with less than 10% incapacity are considered but are specifically identified as "mild permanent occupational diseases" to exclude them from the analysis when necessary.

On the opposite, for severe cases of occupational diseases, the various national systems also do not cover them similarly (degrees of disability sometimes higher than 100%, pension from different level of disability, etc.). This is why all cases with an incapacity degree of 50% or more, including more than 100% and pension are considered together in one class of the severity classification below.

Finally, the Commission was asked to pay attention to the fact that the degrees of permanent disability assigned to occupational diseases correspond, according to the Member States, either to:

- Only a physiological incapacity;
- Only an economical incapacity;
- A mixed evaluation including both a physiological and an economical incapacity.

Consequently, a degree of permanent incapacity apparently the same for 2 diseases in 2 different Member States could represent in reality very different situations. To solve this problem it is proposed the following:

- To indicate in the national data the degrees of incapacity with the same EODS classification below for all Member States, whatever the administrative meaning of these degrees;
- To inform Eurostat on which type of incapacity, physiological, economical or mix one, is used in the national system to established the incapacity degrees provided;
- Eurostat will develop separate analyses for the 3 groups of Member States (with physiological, economical or mixed degrees of incapacity) and will always present the results breakdown between these 3 groups.

For cases for which problems will still remain to define the incapacity in a sufficiently comparable way, 2 codes are included in the classification below both for temporary and permanent diseases with sick leave or level of disability not specified.

2 Organization of data

The following variables should be recorded for each recognised case included according the general inclusion criteria (diagnostic event), using the classifications listed in Appendix B:

Variable	Number of characters	Starting position	Character format	Variable type
Case number	**9** characters	**1**	Numeric	Numeric
Country of emergence	2 characters	**10**	Alphanumeric	Classification
Age	2 characters	**12**	Numeric	Numeric
Sex	1 character	**14**	Numeric	Categorical Class
Occupation at time of Harmful exposure	2 characters	**15**	Numeric	Classification
Economic activity of Employer at time of harmful exposure	2 characters	**17**	Numeric	Classification
European Schedule Reference N° (new Schedule only)	5 characters	**19**	Numeric	Classification
Diagnosis (ICD10)	**4 characters**	**24**	**Alphanumeric**	**Classification**
Severity of Disease	**3 characters**	**28**	**Alphanumeric**	**Classification**
Exposure : Short or long list	**10 characters**	**31**	**Numeric**	**Classification**
Exposure : Use categories	**3 characters**	**41**	**Alphanumeric**	**Classification**
Year for the first recognition	**4 characters**	**44**	**Numeric**	**Numeric**
Severity of Disease for first recognition	**3 characters**	**48**	**Numeric**	**Classification**
Total	**50 characters**			

3 Case-by-case-data-transfer

In order to facilitate the evaluation of the data and the analysis it is strongly recommended to submit case-by-case data.

4 Variable characterization

4.0 CASE NUMBER

A unique case number must always be supplied when case-by-case data are transmitted. This is required to identify each individual record, to ensure that each record represents a separate case of an occupational disease, and, when the case arises, to answer any queries which involve the retrieval and correction of a single record. The format for the case number is to be determined by the Member State, although it must be prefixed by the last **4** digits of the year where the occupational disease have been recognised by the authorities (first year : **2001**). For that reason, the first **4** digits of the case number represent the reference year for the collected data, and the last 5 numbers are determined freely by the Member State.

4.1 COUNTRY OF EMERGENCE

The country of emergence is defined as the country where the disease was contracted and recognised because a disease is only recognised by the country of origin. As already said in the introduction, Germany does not participate to Phase 1.

For a case by case data transfer (see below) to Eurostat each data record should contain information identifying the country of emergence classified according to the ISO 3166 nomenclature at the two-character level (Appendix A).

4.2 AGE

For the case-by-case data the age is in this case represented by the age (in numbers of years) of the victim at the time of recognition of the disease. The format for the variable "age" is 'yy' and a value for missing data is accepted (99). For aggregated data the age of the person should be recorded according to the categories that appear in the layout for the transfer-tables (Appendix A).

4.3 SEX

Sex is a simple categorical variable. The variable "sex" is accepted with a value for missing data (9). (Appendix A)

4.4 OCCUPATION

The victim's occupation in the period of harmful exposure is classified according to a short version (2 digit level) of the ISCO-88 (COM). The "occupation" variable is accepted with a value for missing data (99). (Appendix A)

4.5 ECONOMIC ACTIVITY OF THE EMPLOYER

The type of economic activity of the employer of the period of harmful exposure is classified according to a short version (2-digit level) of the NACE, Rev 1. The "economic activity" variable is accepted with a value of missing data. For the NACE code missing data must be entered as a string of blanks '_ _' (00). (Appendix A)

4.6 EUROPEAN SCHEDULE REFERENCE N°

Notice! The inclusion of this variable will depend of the results of the activities of the Working Group lead by Direction General Employment and social affairs of the European Commission for the revision of the European Schedule of Occupational Diseases. The codification according to the 1990's Schedule is not relevant. The variable "European Schedule Reference N°" provides an indicator for agent and/or type of exposure. The Schedule also provides a reference to the information notices on occupational diseases, and thus explanatory notes for the various items in the Schedule.

4.7 DIAGNOSIS

Information on diagnosis is classified according to the ICD 10 nomenclature. The subset of diagnosis groups based on the ICD 10 and covered by Phase 1 is provided in Appendix B.

4.8 EXPOSURE

Information on exposure should be classified in accordance with the classification provided in the publication "Eurostat Working Paper series, Population and social conditions 3/2000/E/n°18 – Classification of the causal agents of the occupational diseases (in all official European languages) – EODS"[6]. Either the long or the short version of the exposure classification can be used (the long version is optional).

4.9 EXPOSURE: USE CATEGORIES

Information on use categories (product containing the exposure agent) should be classified in accordance with the classification provided in the publication "Eurostat Working Paper series, Population and social conditions 3/2000/E/n°18 – Classification of the causal agents of the occupational diseases (in all official European languages) – EODS"[6].

4.10 SEVERITY OF DISEASE

Classification in Appendix A.

For permanent disabilities (inclusion criteria 2 – compulsory - and 4 or 5 – optional -), the degree of disability (%) should include "true" values of 10 % or more, provided in size bands (B02 to B05). In addition, data on permanent incapacity less than 10 % are not available in some national systems or are not covered similarly among the Member States. Consequently a predefined value (= B01) should be dedicated for mild cases of permanent occupational disease (i.e. recognised but considered to have a degree of disability *less* than 10 %). This code will allow excluding these cases if necessary when doing comparison analysis. Finally, values of disability above 49 % (including 100% or more and pension) should be entered as code B06.

[6] Rosa Pascalicchio C/O World Systems Ltd & Eurostat – Unit E3, November 2000, document available at Eurostat E3 secretariat, cf. cover page of the current Working Paper.

This classification should be used either for physiological, administrative or mixed evaluation of the degree of disability, as the breakdown between these 3 groups of systems used by the Member States will be done by Eurostat that will carry out separate analysis for each of these 3 groups. However, for cases that have been recognised as a permanent occupational disease but for which no degree of disability could be specified in a comparable way, the code B00 should be entered.

For some occupational diseases most cases are recognised only for a temporary sick leave during the reference year after which either they are considered to be completely cured or rehabilitated or can evolve to a permanent disease but only after the end of the reference year. Such cases should be coded as *temporary diseases*. For cases of temporary occupational disease (inclusion criteria 2), the total duration (days) of sick leave (> 3 days) due to the disease during the reference year should be entered in the appropriate sizeband (code A02 – A08). For occupational diseases recognised for a temporary incapacity leading to a sick leave of less than 4 days, the differences between the national compensation systems are important. This is why a predefined value (= A01) should be dedicated for mild cases of temporary occupational disease (i.e. recognised but with less than 4 days sick leave and no permanent degree of disability). This code will allow excluding these cases if necessary when doing comparison analysis.

It is important *not to mix in the data cases temporary occupational diseases (codes from A00 to A08) with cases with permanent mild occupational diseases or permanent occupational diseases with not specified degree of disability (codes B00 and B01), even if at the analysis level they would be some time considered together.*

Cases which were recognised for the first time *only post-mortem* or more generally all fatalities due to an occupational disease (inclusion criteria 2 and 3) are coded 998 for the reference year of the incidence of the death.

4.11 YEAR FOR FIRST RECOGNITION

The year for first recognition should be coded for all cases. However, for those cases which are recognised for the first time, i.e., the incident cases inclusion criteria 1-2, the "Year for the first recognition" and the "reference year" would be the same.

For prevalent cases, which have been, recognised previously, the year for the first recognition should be entered. Those cases of particular interest are the following in Phase 1:

- In a compulsory way, cases where the person died during the reference year because of the occupational disease which had been recognised previously either as temporary or permanent disease (inclusion criteria 3).
- In an optional and pilot way, cases which have changed "status", i.e., either from a temporary to a permanent occupational disease or where the level of disability have been changed during the reference year (inclusion criteria 4 and 5).

4.12 SEVERITY OF DISEASE FOR THE FIRST RECOGNITION

The "Severity of disease" for the first recognition should be coded for all cases. However, for those cases which are recognised for the first time, i.e., the incident cases inclusion criteria 1-2, the "Severity of Disease" for the first recognition" and the "Severity of Disease recognised in the reference year" would be the same.

For prevalent cases which have been recognised previously with a first severity (either temporary or permanent), the code for the "Severity of Disease" for the first recognition should be entered. Those cases of particular interest are the following in Phase 1:

- In a compulsory way, cases where the person died during the reference year because of the occupational disease which had been recognised previously either as temporary or permanent disease (inclusion criteria 3).
- In an optional and pilot way, cases which have changed "status", i.e., either from a temporary to a permanent occupational disease or where the level of disability have been changed during the reference year (inclusion criteria 4 and 5).

See also point 4.10 and classification in Appendix A.

ANNEX A: Classifications to be used in the Phase 1.

For the variable Diagnosis, please see Annex B page 17.

For the Exposure variables, the classification is provided in the publication "Eurostat Working Paper series, Population and social conditions 3/2000/E/n°18 – Classification of the causal agents of the occupational diseases (in all official European languages) – EODS".

COUNTRY OF EMERGENCE (NUTS)

BE Belgium
DK Denmark
DE Germany
GR Greece
ES Spain
FR France
IE Ireland
IT Italy
LU Luxembourg
NL the Netherlands
AT Austria
PT Portugal
FI Finland
SE Sweden
UK United Kingdom

AGE

For the case-by-case the true value of the age for the injured person at time of first recognition has the format 'yy', and the value '99' is allowed when year of birth is unknown.

If only aggregated data is provided, **although it is strongly not recommended**, the following the format it should be used:

0 0-17
1 18-24
2 25-34
3 35-44
4 45-54
5 55-64
6 65 or more
9 Age unknown

SEX

1 Man
2 Woman
9 Sex unknown

SEVERITY OF DISEASE

000 Severity of disease unknown

Temporary incapacity (to work) (first recognition of temporary disability during the reference year and no permanent incapacity recognised during the reference year, inclusion criteria 2)

A00 **Temporary** occupational disease, sick leaves not specified
A01 0-3 days lost (temporary mild cases)
A02 4-6 days lost
A03 7-13 days lost
A04 14-20 days lost
A05 At least 21 days lost, but less than 1 month
A06 At least 1 month but less than 3 months lost
A07 At least 3 months lost but less than 6 months lost
A08 6 months or more lost

Permanent incapacity (to work) (for the reference year where the degree of permanent disability is settled, either the first degree in case only inclusion criteria 2 is used, or a new degree for the optional inclusion criteria 4 – 5)

B00 **Permanent incapacity (to work)** without pension, level of disability not specified
B01 level of disability, 9% or less (permanent mild cases)
B02 level of disability, from 10 % to 14%
B03 level of disability, from 15 % to 19%
B04 level of disability, from 20 % to 29%
B05 level of disability, from 30 % to 49%
B06 level of disability, 50 % or more (including > 100%) or pension

998 **Death** (all fatalities due to an occupational disease are coded 998 for the reference year of the incidence of the death, inclusion criteria 2 - 3)

999 Severity of disease, not elsewhere mentioned

OCCUPATION [ISCO 88 (COM), LEVEL 2]

00 Armed forces without specification
10 Legislators, senior officials and managers without specification
11 Legislators and senior officials
12 Corporate managers
13 General managers
20 Professionals without specification
21 Physical, mathematical and engineering science professionals
22 Life science and health professionals
23 Teaching professionals
24 Other professionals
30 Technicians and associate professionals without specification
31 Physical and engineering science associate professionals
32 Life science and health associate professionals
33 Teaching associate professionals
34 Other associate professionals
40 Clerks without specification
41 Office clerks
42 Customer service clerks
50 Service workers and shop and market sales workers without specification
51 Personal and protective services workers
52 Models, salespersons and demonstrators
60 Skilled agricultural and fishery workers without specification
61 Market-oriented skilled agricultural and fishery workers
62 Subsistence agricultural and fishery workers
70 Craft and related trades workers without specification
71 Extraction and building trades workers
72 Metal, machinery and related trades workers
73 Precision, handicraft, printing and related trades workers
74 Other craft and related trades workers
80 Plant and machine operators and assemblers without specification
81 Stationary-plant and related operators
82 Machine operators and assemblers
83 Drivers and mobile-plant operators
90 Elementary occupations without specification
91 Sales and services elementary occupations
92 Agricultural, fishery and related labourers
93 Labourers in mining, construction, manufacturing and transport
99 Not elsewhere mentioned or unknown

EMPLOYER'S ECONOMIC ACTIVITY [NACE, REV 1, LEVEL 2]

'_'_' Economic activity unknown
01 Agriculture, hunting and related service activities
02 Forestry, logging and related service activities
05 Fishing, operation of fish hatcheries and fish farms; service activities incidental to fishing
10 Mining of coal and lignite; extraction of peat
11 Extraction of crude petroleum and natural gas; service activities incidental to oil and gas extraction excluding surveying
12 Mining of uranium and thorium ores
13 Mining of metal ores
14 Other mining and quarrying
15 Manufacture of food products and beverages
16 Manufacture of tobacco products
17 Manufacture of textiles
18 Manufacture of wearing apparel; dressing and dyeing of fur
19 Tanning and dressing of leather; manufacture of luggage, handbags, saddlery, harness and footwear
20 Manufacture of wood and products of wood and cork, except furniture; manufacture of articles of straw and plaiting materials
21 Manufacture of pulp, papers and paper products
22 Publishing, printing and reproduction of recorded media
23 Manufacture of coke, refined petroleum products and nuclear fuel
24 Manufacture of chemicals and chemical products
25 Manufacture of rubber and plastic products
26 Manufacture of other non-metallic mineral products
27 Manufacture of basic metals
28 Manufacture of fabricated metal products, except machinery and equipment
29 Manufacture of machinery and equipment n.e.c.
30 Manufacture of office machinery and computers
31 Manufacture of electrical machinery and apparatus n.e.c.
32 Manufacture of radio, television and communication equipment and apparatus
33 Manufacture of medical, precision and optical instruments, watches and clocks
34 Manufacture of motor vehicles, trailers and semi-trailers
35 Manufacture of other transport equipment
36 Manufacture of furniture; manufacturing n.e.c.
37 Recycling
40 Electricity, gas, steam and hot water supply
41 Collection, purification and distribution of water
45 Construction
50 Sale, maintenance and repair of motor vehicles and motorcycles; retail sale of automotive fuel
51 Wholesale trade and commission trade, except of motor vehicles and motorcycles
52 Retail trade except of motor vehicles and motorcycles; repair of personal and household goods
55 Hotels and restaurants
60 Land transport; transport via pipelines

61 Water transport
62 Air transport
63 Supporting and auxiliary transport activities; activities of travel agencies
64 Post and telecommunications
65 Financial intermediation, except insurance and pension funding
66 Insurance and pension funding, except compulsory social security
67 Activities auxiliary to financial intermediation
70 Real estate activities
71 Renting of machinery and equipment without operator and of personal and house
72 Computer and related activities
73 Research and development
74 Other business activities
75 Public administration and defence; compulsory social security
80 Education
85 Health and social work
90 Sewage and refuse disposal, sanitation and similar activities
91 Activities of membership organisations n.e.c.
92 Recreational, cultural and sporting activities
93 Other service activities
95 Private households with employed persons
99 Extra-territorial organisations and bodies.

ANNEX B: Disease specific inclusion criteria.

The following diagnoses in the table below are included in EODS Phase 1. Some of the diagnostic entities are clear as such and no specific inclusion criteria are given. On the opposite when specific explanations and criteria are required, they are given.

The codes are according to ICD-10, 4-digit level. Where a subdivision below 3-digit level is either not needed or does not exist, the character X has been added to achieve a length of 4-digit.

Some of the diagnostic entities are mentioned as such in the national lists, but for many of them cases can occur also under the chemical, agent or exposure defined categories of the national list. It is important to include and code also these cases. For example in asthma, both the cases recognised under the general item of asthma and the cases of asthma recognised under the agent defined categories of the national list should be coded as asthma. **The differentiation according to causative factor will be made with the separate variables "Exposure causing occupational diseases" - long or short list - and "use categories".**

Some of the diagnostic entities are such that the patient may be recognised for several closely related diseases at the same time (asthma and rhinitis, rhinitis and conjunctivitis, pneumoconiosis and chronic bronchitis). Some member states keep record of both diagnoses while some do not. **Therefore it has been decided that in EODS Phase 1 data only the most severe one of the diagnoses due to one exposition should be identify as a case and coded**. However, it has also been decided that the EODS Technical Subcommittee will continue studying this point in view to specifying a rule more adapted to all possible situations (cases of 2 or more very different diagnoses due to a same exposition) for data collection for years further than 2001. Specific explanations are mentioned below.

CANCERS

LIVER CANCER	C22X
CANCER OF THE NASAL CAVITY Exclusion: Cases recognised only for benign lesions (i.e. ulceration J340, perforationsJ348) are not included in C300.	C300
CANCER OF THE ACCESSORY SINUSES	C31X
LARYNGEAL CANCER	C32X
LUNG CANCER Notice that both lung cancer cases, which were recognised under the chemical, defined categories and cases recognised because of exposure to asbestos are included here. Exclusion: Cases of other asbestos-related disease should not be coded as lung cancers (mesothelioma, laryngeal cancer, asbestosis).	C34X

SKIN CANCER Inclusion: All forms of skin cancer. Exclusion: Cases with precancerous skin lesions (see D04X), contact dermatitis (L23X-L25X) or ulcerations or chemical burns (not at all included) should not be coded as skin cancer	C44X
MESOTHELIOMA Inclusion: All sites of mesothelioma (pleura, peritoneum, pericardium etc.) Exclusion: Cases of other asbestos-related cancers should not be coded as mesothelioma (lung cancer, laryngeal cancer). Benign diseases of pleura diseases should not be coded as mesothelioma (diffuse thickening, pleural plaques).	C45X
BLADDER CANCER Inclusion: All forms of bladder cancer. (It needs to be discussed whether cases with cancer of the other urinary tract, i.e. renal pelvis, urethers and urethra should be coded here or separately) Exclusion: Cases with benign lesions of the bladder (not included at all) should not be coded as bladder cancer.	C67X
LEUKAEMIA Inclusion: All forms of leukaemia whatever the causative agent. Exclusion: Non-malignant haematological conditions should not be coded as leukaemia (anaemia, agranulocytosis, trombocytopenia).	C95X
PRECANCEROUS SKIN LESIONS	D04X

RESPIRATORY DISEASES

ASTHMA Inclusion: All the cases recognised as bronchial asthma. It is important to include also those cases of asthma, which were recognised under the chemical defined categories of the national lists. Exclusions: Cases recognised for chronic bronchitis (J44X) or chronic cough without diagnosis of asthma (not included at all) should not be included.	J45X
ALLERGIC RHINITIS Inclusion: All the cases recognised as allergic rhinitis. It is important to include also those cases of allergic rhinitis, which were recognised under the chemical defined categories of the national lists. Exclusion: Cases recognised for irritant rhinitis/non-specific rhinitis (not included at all), nasal ulceration (J340) or perforation (J348) should not be included. Note: Asthma and allergic rhinitis are frequently combined. If the patient is recognised at the same time for both of these, the case should be systematically included only in ASTHMA.	J303

ALLERGIC ALVEOLITIS Inclusion: All the cases recognised as allergic alveolitis, i.e. hypersensitivity pneumonitis. It is important to include also those cases of allergic alveolitis, which were recognised under the chemical defined categories of the national lists. Exclusion: Cases recognised for byssinosis (J660) or pneumonia (not included at all) should not be included.	J67X
NASAL ULCERATION	J340
NASAL PERFORATION	J348
CHRONIC BRONCHITIS Inclusion: All cases recognised for chronic bronchitis or chronic bronchitis with emphysema. Exclusion: If the same case is recognised for any of the pneumoconioses at the same time, it should be coded only as a case of pneumoconiosis.	J44X
ASBESTOSIS Inclusion: All cases recognised for asbestos-related pulmonary fibrosis. Exclusion: Cases recognised for asbestos-related pleural diseases should not be coded as asbestosis. Yet, if the patient has both asbestosis and a pleural disease, the case should be coded as asbestosis. If the case is recognised for asbestos-related malignant disease and has asbestosis at the same time, the case should be coded according to the malignancy.	J61X
DIFFUSE THICKENING OF THE PLEURA Inclusion: All cases recognised for diffuse pleural thickening. Exclusion: Cases recognised for pleural plaques or pleural effusion should not be coded as here. Yet, if the patient has both diffuse thickening of the pleura and pleural plaques (or pleural effusion) the case should be coded as diffuse thickening of the pleura. If the case is recognised for asbestos-related malignant disease and has diffuse thickening of the pleura at the same time, the case should be coded according to the malignancy.	J948
PLEURAL PLAQUES Inclusion: All cases recognised for pleural plaques. Exclusion: If the case is recognised at the same time for asbestosis, diffuse pleural thickening, pleural effusion or a malignant disease, it should be coded according to that disease and not as pleural plaques.	J92X
PLEURAL EFFUSION Inclusion: All cases recognised for pleural effusion. Exclusion: If the case is recognised at the same time for a asbestosis, diffuse pleural thickening or a malignant disease, it should be coded according to that disease and not as pleural effusion.	J90X

COAL WORKER'S PNEUMOCONIOSIS Inclusion: All cases recognised for pneumoconiosis due to coal dust. Exclusion: Cases recognised for chronic bronchitis or emphysema caused by exposure to coal dust should be coded as cases of chronic bronchitis (J44X) if a pneumoconiosis is not present. Note: Some member states do not recognise coal worker's pneumoconiosis, but recognise pneumoconiosis in a coal worker if it is consistent with silicosis. At the same time many of them have a separate category for chronic bronchitis/emphysema of coal workers. As far as pneumoconiosis is concerned, a silicosis in a coal worker is more or less the same as a coal worker's pneumoconiosis. The best solution is that member states code them according their practice (either silicosis or CWP) and in the analyses Coal workers as an occupation (or industry) are separated from the rest when pneumoconiosis are analysed.	J60X
SILICOSIS Inclusion: All cases recognised for pneumoconiosis caused by exposure to crystalline silica. Comment: the national lists differ in whether only crystalline silica or silicates in general are mentioned. ICD-10 is also confusing in these codes. It would be useful to separate "real" silicosis (crystalline silica) and the rest. It can be done either by exposure codes or by the principle mentioned in the exclusion below. Exclusion: Cases recognised for pneumoconiosis due to silicates other than crystalline silica should be coded as J638 (pneumoconiosis caused by other inorganic dusts).	J62X
PNEUMOCONIOSIS ASSOCIATED WITH TUBERCULOSIS All cases recognised for tuberculosis as a complication of any pneumoconiosis	J65X
PNEUMOCONIOSES DUE TO OTHER SILICATES Exclusion (compulsory part) : Rare pneumoconioses = Aluminosis – J630, Bauxite fibrosis of lung - J631, Beryllosis - J632, Graphite fibrosis of lung - J633, Siderosis - J634, Stannosis - J635 (However, these 6 diagnoses can be included on an optional way, see p. 24)	J638
BYSSINOSIS	J660
HARD METAL DISEASE Hard metal disease includes cases of asthma, rhinitis or pulmonary fibrosis caused by dusts from hard metals. Cases of asthma should be coded as asthma (J45X), cases of rhinitis as allergic rhinitis (J303) and cases of fibrosis as J841 (other interstitial pulmonary fibrosis).	

NEUROLOGICAL DISEASES

CARPAL TUNNEL SYNDROME Inclusion: All cases recognised for carpal tunnel syndrome. Exclusion: Cases of other nerve paralysis should not be coded as carpal tunnel syndrome. Proposition of codes for these are presented below in possible extensions of the code list.	G560
TOXIC ENCEPHALOPATHY	G92X
POLYNEUROPATHY	G622

DISEASES OF THE SENSORY ORGANS

CATARACTS	H268
NOISE-INDUCED HEARING LOSS	H833

CARDIOVASCULAR DISEASES

RAYNAUD'S SYNDROME (secondary) Inclusion: Cases with vibration-induced (or other) peripheral vascular disease of the hand. Exclusion: Cases with vibration induced arthrosis (M192, M931), polyneuropathy (G622) or mononeuropathy (e.g. carpal tunnel sdr) should not be coded as I730. If several vibration-induced effects are recognised at the same time, the coding should be done according to the most severe of these. A proposition is to rank them as follows: 1. arthrosis, 2 polyneuropathy, 3. mononeuropathy, 4. Raynaud's sdr	I730

SKIN DISEASES

ALLERGIC CONTACT DERMATITIS IRRITANT CONTACT DERMATITIS UNSPECIFIED CONTACT DERMATITIS Inclusion: All recognised cases of contact dermatitis should be included according to their allergic or irritant nature. If separation of allergic and irritant cases is not possible, the code L25X should be used. Please note also the comment concerning contact urticaria. Exclusion: Cases with skin cancer (C44X), precancerous skin lesion (D04X) or ulcerations or chemical burns (not included at all) should not be coded as L23X, L24X or L25X.	L23X L24X L25X
CONTACT URTICARIA Inclusion: Cases recognised for contact urticaria. Note: Some member states may include such cases to allergic contact dermatitis. If most of them do so, all should do it in the data collection.	L506
ACNE	L708

MUSCULOSKELETAL DISEASES

ARTHROSIS OF THE ELBOW Inclusion: All cases recognised for arthrosis of the elbow. Exclusion: Cases recognised for arthrosis of any other joints than elbow or wrist (M931) are not included at all in the data collection.	M192
ARTHROSIS OF THE WRIST Inclusion: All cases recognised for arthrosis of the wrist. (This is not fully according to the ICD-10 code M931 but probably the best solution)	M931

DEGENERATIVE LESIONS OF THE MENISCUS (knee) Inclusion: All cases recognised for meniscal disorders of the knee. Exclusion: Acute knee injuries should not be included in this category. It is preferable to include them in accidents at work.	M232
BURSITIS OF ELBOW	M703
BURSITIS OF KNEE	M704
TENOSYNOVITIS OF THE HAND AND WRIST Inclusion: All cases recognised for tendinitis, tenosynovitis, and peritendinitis of the hand or wrist.	M700
MEDIAL EPICONDYLITIS (elbow)	M770
LATERAL EPICONDYLITIS (elbow)	M771

INFECTIONS

A general exclusion for infectious diseases is that cases recognised just for immunity testing, preventive vaccination and any other cases without an infection should be excluded whatever reimbursement was associated.

Below are listed 11 infections, covered by most OD schemes and then **included in EODS Phase 1 from 2001 onwards on a compulsory way**. Many of the national lists, however, mention broad categories like "Infections transmitted from animals", "Infectious diseases in health care and related workers" and "Tropical diseases". To collect more data on what is behind such categories, a further list of (probably) relevant codes follows on next page. This additional list could to be used on an optional way by Member States that already collect data on these diagnoses and want to include them in their EODS Phase 1 data.

TUBERCULOSIS Inclusion: All cases recognised for tuberculosis in any organ should be included in 15X.	A15X
BRUCELLOSIS Inclusion: All cases recognised for infections caused by *Brucella* species	A23X
ERYSIPELOID	A26X
LEPTOSPIROSIS	A27X
HEPATITIS A	B15X
HEPATITIS B	B16X
HEPATITIS C	B171
HEPATITIS E	B172
OTHER SPECIFIC HEPATITIS	B178
HIV	B24X
ANCYLOSTOMIASIS	B760

The following **additional infectious diseases** (with indication of the corresponding ICD-10 codes) **could be included EODS Phase 1 on an optional way** by Member States that already collect data on these diagnoses and want to insert them in their EODS Phase 1 data submitted to Eurostat :

CHOLERA - A00X , TYPHOID AND PARATYPHOID FEVER - A01X, SALMONELLOSIS - A02X, SHIGELLOSIS - A03X, OTHER BACTERIAL INTESTINAL INFECTION - A048, AMOEBIASIS - A06X, TULARAEMIA - A21X, ANTHRAX - A22X, TETANUS - A35X, DIPHTERIA - A36X, ERYSIPELAS - A46X, BORRELIOSIS - A692, ORNITHOSIS - A70X, AVIAN CHLAMYDIOSIS (code to be defined), Q FEVER - A78X, RICKETTSIOSIS - A79X, POLIOMYELITIS - A80X, RABIES - A82X, HAEMORRHAGIC FEVER - A988, VARICELLA - B01X, MEASLES - B05X, RUBELLA - B06X, MUMPS - B26X, DERMATOPHYTOSIS - B358, MALARIA - B54X.

CODING OF THE TOXIC AND IRRITANT EFFECTS

The coding of acute, subacute and chronic toxic and irritant effects of chemicals is complicated. Cancers, asthma, allergic rhinitis, chronic bronchitis, polyneuropathy, toxic encephalopathy and contact dermatitis have been explained above. The remaining disorders, i.e. haematological, some neurological, some respiratory, hepatic, gastrointestinal and nephrological effects could ideally be separated. According to the pilot data the number of such cases is probably not very high and the questionnaire data indicate that it may prove difficult for many Member States to distinguish between these outcomes as they are coded according to causative agent without too much classification according to the medical diagnosis. However it has been decided to include these diagnoses.

Consequently, **the 13 following diagnoses with the corresponding codes are covered by EODS Phase 1 from 2001 onwards :**

HAEMOLYTIC ANAEMIA	D59X
ANAEMIA	64X
SECONDARY THROMBOCYTOPENIA	D685
AGRANYLOCTOSIS AND NEUTROPENIA	D70X
BRONCHITIS (ACUTE) OR PNEUMONITIS	J680
PULMONARY OEDEMA	J681
UPPER RESPIRATORY INFLAMMATION	J682
REACTIVE AIRWAYS DYSFUNCTION SYNDROME	J683
PULMONRAY FIBROSIS	J841
TOXIC LIVER DISAESE	K71X
TUBULO-INTERSTITIAL KIDNEY DISEASES	N14X
CHRONIC RENAL FAILURE	N18X
COLIC AND OTHER GASTROINTESTINAL SYMPTOMS	R10X

POSSIBLE EXTENSIONS OF THE CODE LIST (OPTIONAL IN PHASE 1)

The following codes represent entities, which are either rare as occupational diseases or very heterogeneously dealt in the national lists. **They are not included on a compulsory way in Phase 1 data collection. However, they could be included in EODS Phase 1 on an optional way** by Member States that already collect data on these diagnoses and want to insert them in their EODS Phase 1 data submitted to Eurostat :

MONONEUROPATHIES
Other lesions of the median nerve, G561
Lesion of the ulnar nerve, G562
Lesion of the radial nerve, G563
Lesion of the lateral popliteal nerve, G573
Tarsal tunnel syndrome, G577
OTHER NEUROLOGICAL DISEASES
Secondary parkinsonism, G212
Amyotrophic lateral sclerosis, G122
Intentional tremor, G252
Epilepsy, G40X
Disorders of the trigeminal nerve, G50X
EYE DISORDERS
Conjunctivitis, H10X
Exclusion: Cases which are at the same time recognised for conjunctivitis and allergic rhinitis or conjunctivitis and asthma, should be coded only as allergic rhinitis and asthma, respectively.
RARE PNEUMOCONIOSES
Aluminosis, J630
Bauxite fibrosis of lung, J631
Beryllosis, J632
Graphite fibrosis of lung, J633
Siderosis, J634
Stannosis, J635

DISEASES NOT INCLUDED ABOVE

There are numerous diagnostic entities, which are recognised as occupational diseases in some of the member states. The above list contains those entities, which are recognised by most of them. The following exclusions have been made for 2001 (**not included in Phase 1 data collection)** :

Some cancers.
Some infections.
Back pain, neck pain and shoulder pain, and related disorders (open list only, not at all or as accidents in most Member States).
Mental and behavioural disorders (not at all included in the recognition practice in most Member States).

ANNEX C: FINAL REPORT - Draft proposal concerning inclusion criteria, coding of severity and coding of diagnosis for the eods data collection - Results of the questionnaire on national recognition criteria and assessment of severity of disease – Dr Antti Karjalainen, Finnish Institute of Occupational Health - June 2000.

INTRODUCTION

A pilot project assessed the comparability of statistical data on occupational diseases at the European Union level and proposed improvements for the next data collection procedure of recognised occupational diseases in the EU Member States. The pilot project report was published in 1999 and proposed the following improvements for the next EODS data collection:

1. Definition of the reference population
2. Definition of the inclusion criteria
3. Classification/Coding of the medical diagnosis
4. A solution of the problem arising from variation in the recognition of mild occupational diseases

Points 2-4 above represent disease-specific problems of comparability.

The aim of the current operation was to set up well-defined inclusion criteria and adequate classifications for the medical diagnosis and severity of disease for the next data collection.

AIMS AND METHODS

The main aims of the present project were:

1. To set up a draft list of ICD-10 codes for coding of the medical diagnosis.
2. To set up a detailed questionnaire concerning the following issues: national recognition criteria and assessment of severity of disease. These issues are by nature very disease-specific and had to be dealt item by item.
3. To prepare, on the basis of the answers to the questionnaire, the inclusion criteria specifications and the classification on severity of the diseases, to be discussed with the EODS Technical sub-committee and EODS Working group of Eurostat.

In addition to the above, the operation was expected to provide documented background information on the national recognition criteria etc., collected with the above questionnaire. This information is necessary for the interpretation and understanding of the data to be collected with the above-mentioned inclusion criteria and classifications.

The milestones of the project were as follows:

Date	Task/deliverable
July 2, 1999	Contract signed
September 3, 1999	Bilateral meeting at Eurostat/DG Employment and Social Affairs. Discussion of the prepared draft questionnaire.
September 17, 1999	Submission of the revised draft questionnaire to Eurostat and consequently to the Member States
November 3, 1999	EODS Technical sub-committee meeting. Comments of the Member States concerning the draft questionnaire.
November 4, 1999	Bilateral meeting at Eurostat. Discussion of the comments from the Member States and decision on the revisions to be made.
November 12, 1999	Submission of the finalised questionnaire to Eurostat and consequently to the Member States
December 10, 1999	Deadline for the filled questionnaire to be returned from the Member States (the last questionnaire was received by January 18, 2000).
January 31, 2000	Submission of the draft proposal of inclusion criteria and coding of severity of disease and of medical diagnosis (a preliminary draft for translation purposes submitted on January 21).
February 16, 2000	EODS Technical sub-committee meeting. Discussion of the draft proposal of inclusion criteria and coding of severity of disease and of medical diagnosis.
February 17, 2000	Bilateral meeting at Eurostat. Discussion of the comments of the Technical sub-committee
June 6, 2000	Submission of the final report.
June 17, 2000	End of project

RESULTS

According to the results of the questionnaire, the experience from the 1995 pilot data and the comments from the Member States, drafts for general and disease-specific inclusion criteria and a coding for severity of disease and for medical diagnosis were prepared. These drafts are presented in Part 1 of this report.

PART 1 - DRAFT PROPOSAL CONCERNING INCLUSION CRITERIA, CODING OF SEVERITY AND CODING OF DIAGNOSIS FOR THE EODS DATA COLLECTION

INTRODUCTION

This document contains the drafts of the inclusion criteria, coding of severity and coding of medical diagnosis for the next EODS data collection. These propositions are based on the information collected with a questionnaire in December 1999 and the experience from the analysis of the 1995 pilot data. As this is a working document, it also contains comments concerning the propositions. These comments try to clarify the reasons of the choices made and to point out the problems that exist.

GENERAL INCLUSION CRITERIA OF THE MAIN DATA SET

The data collection of incident cases should include all cases which were recognised as occupational diseases during the reference year and which represent the diagnostic entities presented in the disease-specific inclusion criteria. Recognition means that the case was accepted to be a case of occupational disease and had not been accepted previously for the same diagnosis. The date of decision of recognition should be used as the date of reference. No general exclusions are made according to the severity of disease, but adequate variables are included to allow for later analyses concerning severity of disease.

A general exclusion is that no cases which were finally rejected as occupational diseases should be included. Some member states have systems were cases may be eligible for compensation of costs of sick leave during medical investigations or reimbursement of costs of medical investigations according to justified suspicion of an occupational disease. Such cases should not be included if they were finally not accepted as a case of occupational disease.

VARIABLES FOR DIAGNOSIS, TYPE AND SEVERITY OF DISEASE

The following variables are needed:

Diagnosis (according to ICD-10, described in pages 11-17)
Type of disease (see below)
Disability (see below)

The type of disease

This variable refers to the nature of the disease outcome. The following values are needed:

1. a permanent occupational disease
2. a temporary occupational disease
3. death (cases which were recognised for the first time only post-mortem)

Disability

This variable is needed to indicate the severity of disease. For permanent occupational diseases this variable contains the degree of work disability (details follow later) and for temporary occupational diseases it contains the duration of sick leave.

Comments:

A permanent occupational disease means that: (a) the case was recognised (accepted) as an occupational disease and (b) a permanent degree of work disability has been defined for the case for the first time during the reference year. I.e. if the case had been accepted for a temporary sick leave during a previous year, it should nevertheless be included as a permanent OD for the reference year during which it was recognised as a permanent OD in the national system. Note: If the case was recognised first as a temporary OD and then as a permanent OD during the same year, it should be included only as a permanent OD. The degree of work disability (%) should be coded as a separate variable. This variable (3 digits) should include "true" values for disabilities of 10 % or more. In addition a predefined value (= 000) should be dedicated for mild cases of permanent occupational disease which have been recognised but were considered to have a degree of disability less than 10 %.

In some occupational diseases most cases are recognised only for a temporary sick-leave after which they are considered to be completely cured or rehabilitated. Such cases should be coded as temporary occupational diseases. It is important not to mix cases with temporary OD with cases with permanent mild OD. For cases with temporary OD there will be little need for the variable degree of disability, but data need to be collected for the duration of sick leave. This variable (3 digits) should contain the total duration (days) of sick leave due to the occupational disease during the reference year. Cases recognised at the end of the reference year and cases with a long sick leave are problematic for accurate coding of the duration of sick leave. If the statistical data will be collected later than one year after the end of the reference year, the duration of sick leave could be updated for the reference year and the following year.

Death due to an occupational disease is a special outcome. Sometimes it is the first occupational disease event recorded for that case. For example in occupational cancers such cases may constitute an important number of all recognised cases and should be included in the data collection. In the data collection of incident occupational diseases, death is the outcome only for those cases which were recognised for the first time only after death. If the case had been recognised as an occupational disease already previously, but dies later, its inclusion to the data collection is defined by the nature of outcome at first recognition. In most (but not all) systems a degree of disability is not defined for cases recognised only post-mortem. If not coded properly, such cases may be mixed with mild or temporary cases which also do not receive a degree of disability. Therefore it is preferable to use the above coding principle for death and not mix these cases with cases of permanent disease although they usually represent the same diagnoses.

Note: Systematic data collection for fatal occupational diseases necessitates an additional coding practice to separate cases which were recognised due to death from an OD during the reference year regardless of when and at which stage they were recognised for the first time. Fatal cases of OD include mainly cases of cancer and cases of pneumoconiosis. Data for incident cases of such diseases will in any case be collected. Nevertheless, as the next data collection will in any case be also a feasibility test, it is recommended to test also the feasibility of this kind of a data collection.

Problems:

1. According to questionnaire data compensation for sick leave is not included in the compensation system in DK and UK. In addition, the questionnaire data indicate that D and F are not currently able to systematically identify data concerning sick leave in their national system. The minimum duration of sick leave eligible for compensation varies from no limit to 15 days. It will be useful to be able to identify the cases recognised only for sick leave to have more experience of their role in the heterogeneity of the national statistical data.

2. The above limit for degree of disability below which no exact values are collected for permanent occupational diseases (10 % of disability) was chosen, because according to questionnaire data this limit has some role of a cut-point in the national systems in D, F, IRL, I (11%) and FIN. Whereas B, L and P indicate that no limit is used, i.e. at least these three member states could probably provide disability scores even for values below 10 %. UK uses 14 % for most diseases, but 1 % for pneumoconiosis and mesothelioma and 20 % for hearing loss. DK records also values below 10 %. I.e. 10 % is a limit, below which many member states do not record a meaningful value, although many of them recognise these cases as (mild or onset) permanent occupational diseases. If a higher limit is preferred it can anyhow be defined afterwards.

3. As pointed out in the final report of the EODS pilot project, the problems caused by the variation in the national practices of dealing with mild permanent occupational diseases may not be fully resolved by the coding proposed above. The problem that remains is that of the diseases with a progressive nature, which may receive a higher degree of disability later. To be able to estimate the magnitude of this problem in each of the diagnostic entities it would be useful to collect another data set, which would include all cases which had been recognised already earlier, but received a higher degree of disability during the reference year. The same set of variables would be collected as for the data set of incident recognised cases. In addition it would be useful to collect data on the year of original recognition and the degree of disability at that time. I.e. this data set would basically include two types of cases: (1) those previously recognised as mild ODs but reaching a severity level above 10 % during the reference year (e.g. change from 000 recognised two years ago to 15 % this year) and (2) those which already had received a level above 10 % but received a higher level during the reference year (e.g. change from 15 % compensated two years ago to 30 % this year). This data set will provide important information and it is recommended to make also this effort.

4. The information available on degree of physiological impairment or degree of work disability is heterogeneous. Some member states have a variable which is purely a measure of the physiological impairment caused by the disease, some have a variable which has a physiological and a socio-economic component and some have a variable which focuses on the socio-economic impairment caused or estimated to have been caused by the disease. Very few member states have both a physiological and a socio-economic variable so there usually is no choice. The questionnaire data collected on the assessment of the values of these variables reveals a lot of variation in the details of this assessment. It proved also to be reasonably difficult to explain these principles at disease specific level for many member states because there are no specific generally applied national guidelines which would explicitly explain the practices at the level of tests or measures to be used and their reference values. The four case patients presented usually received similar scores but were not at all assessed for D, E, L, NL, S and UK with the exception of case 4 with a noise-induced hearing loss.

CODING OF THE DIAGNOSIS AND DISEASE SPECIFIC INCLUSION CRITERIA

The previously mentioned general inclusion criteria are not repeated in this chapter. The diagnosis codes are mentioned in each of the paragraphs. In the final version, after the discussion, a more condensed list of the codes will be prepared. The codes are according to ICD-10. In codes, where a subdivision below 3-digit level is either not needed or does not exist, the character X has been added to achieve a length of 4-digits.

Some of the diagnostic entities are mentioned as such in the national lists, but for many of them cases can occur also under the chemical, agent or exposure defined categories of the national list. It is important to include and code also these cases. For example in asthma, both the cases recognised under the general item of asthma and the cases of asthma recognised under the agent defined categories of the national list should be coded as asthma. The differentiation according to causative factor will be made with a separate variable, according to the final version of the classification of Eurostat on Exposure causing occupational diseases (long or short list + use categories)[7].

Some of the diagnostic entities are clear as such and no specific inclusion criteria are given. According to the analysis of the pilot data, some of the entities require specific explanations which are given below. Some of the diagnostic entities are such that the patient may be recognised for several closely related diseases at the same time (asthma and rhinitis, rhinitis and conjunctivitis, pneumoconiosis and chronic bronchitis). Some member states keep record of both diagnoses while some do not. Therefore only the most severe one of the diseases should be coded. Specific explanations are mentioned below.

[7] Classification provided in the publication "Eurostat Working Paper series, Population and social conditions 3/2000/E/n°18 – Classification of the causal agents of the occupational diseases (in all official European languages) – EODS". Either the long or the short version of the exposure classification can be used (the long version is optional). See also footnote 6.

CANCERS

LIVER CANCER	C22X
CANCER OF THE NASAL CAVITY Exclusion: Cases recognised only for benign lesions (i.e. ulceration J340, perforationsJ348) are not included in C300.	C300
CANCER OF THE ACCESSORY SINUSES	C31X
LARYNGEAL CANCER	C32X
LUNG CANCER Notice that both lung cancer cases which were recognised under the chemical defined categories and cases recognised because of exposure to asbestos are included here. Exclusion: Cases of other asbestos-related disease should not be coded as lung cancers (mesothelioma, laryngeal cancer, asbestosis).	C34X
SKIN CANCER Inclusion: All forms of skin cancer. Exclusion: Cases with precancerous skin lesions (see D04X), contact dermatitis (L23X-L25X) or ulceration or chemical burns (not at all included) should not be coded as skin cancer	C44X
MESOTHELIOMA Inclusion: All sites of mesothelioma (pleura, peritoneum, pericardium etc.) Exclusion: Cases of other asbestos-related cancers should not be coded as mesothelioma (lung cancer, laryngeal cancer). Benign diseases of pleura diseases should not be coded as mesothelioma (diffuse thickening, pleural plaques).	C45X
BLADDER CANCER Inclusion: All forms of bladder cancer. (It needs to be discussed whether cases with cancer of the other urinary tract, i.e. renal pelvis, urethers and urethra should be coded here or separately) Exclusion: Cases with benign lesions of the bladder (not included at all) should not be coded as bladder cancer.	C67X
LEUKAEMIA Inclusion: All forms of leukaemia whatever the causative agent. Exclusion: Non-malignant haematological conditions should not be coded as leukaemia (anaemia, agranulosytosis, trombocytopenia).	C95X
PRECANCEROUS SKIN LESIONS	D04X

RESPIRATORY DISEASES

ASTHMA Inclusion: All the cases recognised as bronchial asthma. It is important to include also those cases of asthma which were recognised under the chemical defined categories of the national lists. Exclusions: Cases recognised for chronic bronchitis (J44X) or chronic cough without diagnosis of asthma (not included at all) should not be included.	J45X
ALLERGIC RHINITIS Inclusion: All the cases recognised as allergic rhinitis. It is important to include also those cases of allergic rhinitis which were recognised under the chemical defined categories of the national lists. Exclusion: Cases recognised for irritant rhinitis/non-specific rhinitis (not included at all), nasal ulceration (J340) or perforation (J348) should not be included. Note: Asthma and allergic rhinitis are frequently combined. If the patient is recognised at the same time for both of these, the case should be systematically included only in ASTHMA.	J303
ALLERGIC ALVEOLITIS Inclusion: All the cases recognised as allergic alveolitis, i.e. hypersensitivity pneumonitis. It is important to include also those cases of allergic alveolitis which were recognised under the chemical defined categories of the national lists. Exclusion: Cases recognised for byssinosis (J660) or pneumonia (not included at all) should not be included.	J67X
NASAL ULCERATION	J340
NASAL PERFORATION	J348
CHRONIC BRONCHITIS Inclusion: All cases recognised for chronic bronchitis or chronic bronchitis with emphysema. Exclusion: If the same case is recognised for any of the pneumoconioses at the same time, it should be coded only as a case of pneumoconiosis.	J44X
ASBESTOSIS Inclusion: All cases recognised for asbestos-related pulmonary fibrosis. Exclusion: Cases recognised for asbestos-related pleural diseases, should not be coded as asbestosis. Yet, if the patient has both asbestosis and a pleural disease, the case should be coded as asbestosis. If the case is recognised for asbestos-related malignant disease and has asbestosis at the same time, the case should be coded according to the malignancy.	J61X
DIFFUSE THICKENING OF THE PLEURA Inclusion: All cases recognised for diffuse pleural thickening. Exclusion: Cases recognised for pleural plaques or pleural effusion should not be coded as here. Yet, if the patient has both diffuse thickening of the pleura and pleural plaques (or pleural effusion) the case should be coded as diffuse thickening of the pleura. If the case is recognised for asbestos-related malignant disease and has diffuse thickening of the pleura at the same time, the case should be coded according to the malignancy.	J948

PLEURAL PLAQUES Inclusion: All cases recognised for pleural plaques. Exclusion: If the case is recognised at the same time for asbestosis, diffuse pleural thickening, pleural effusion or a malignant disease, it should be coded according to that disease and not as pleural plaques.	J92X
PLEURAL EFFUSION Inclusion: All cases recognised for pleural effusion. Exclusion: If the case is recognised at the same time for a asbestosis, diffuse pleural thickening or a malignant disease, it should be coded according to that disease and not as pleural effusion.	J90X
COAL WORKER'S PNEUMOCONIOSIS Inclusion: All cases recognised for pneumoconiosis due to coal dust. Exclusion: Cases recognised for chronic bronchitis or emphysema caused by exposure to coal dust should be coded as cases of chronic bronchitis (J44X) if a pneumoconiosis is not present. Note: Some member states do not recognise coal worker's pneumoconiosis, but recognise pneumoconiosis in a coal worker if it is consistent with silicosis. At the same time many of them have a separate category for chronic bronchitis/emphysema of coal workers. As far as pneumoconiosis is concerned, a silicosis in a coal worker is more or less the same as a coal worker's pneumoconiosis. The best solution is that member states code them according their practice (either silicosis or CWP) and in the analyses Coal worker's as an occupation (or industry) are separated from the rest when penumoconioses are analysed.	J60X
SILICOSIS Inclusion: All cases recognised for pneumoconiosis caused by exposure to crystalline silica. Comment: the national lists differ in whether only crystalline silica or silicates in general are mentioned. ICD-10 is also confusing in these codes. It would be useful to separate "real" silicosis (crystalline silica) and the rest. It can be done either by exposure codes or by the principle mentioned in the exclusion below. Exclusion: Cases recognised for pneumoconiosis due to silicates other than crystalline silica should be coded as J638 (pneumoconiosis caused by other inorganic dusts).	J62X
PNEUMOCONIOSIS ASSOCIATED WITH TUBERCULOSIS All cases recognised for tuberculosis as a complication of any pneumoconiosis	J65X
PNEUMOCONIOSES DUE TO OTHER SILICATES The inclusion criteria of this category are defined after the decision concerning the use of the codes mentioned in page 39	J638
BYSSINOSIS	J660
HARD METAL DISEASE Hard metal disease includes cases of asthma, rhinitis or pulmonary fibrosis caused by dusts from hard metals. Cases of asthma should be coded as asthma (J45X), cases of rhinitis as allergic rhinitis (J303) and cases of fibrosis as J841 (other interstitial pulmonary fibrosis). The exposure classification should include a code for Dusts from hard metals.	

NEUROLOGICAL DISEASES

CARPAL TUNNEL SYNDROME Inclusion: All cases recognised for carpal tunnel syndrome. Exclusion: Cases of other nerve paralysis should not be coded as carpal tunnel syndrome. A proposition of codes for these are presented in the chapter Possible extensions of the code list.	G560
TOXIC ENCEPHALOPATHY	G92X
POLYNEUROPATHY	G622

DISEASES OF THE SENSORY ORGANS

CATARACTS	H268
NOISE-INDUCED HEARING LOSS	H833

CARDIOVASCULAR DISEASES

RAYNAUD'S SYNDROME (secondary) Inclusion: Cases with vibration-induced (or other) peripheral vascular disease of the hand. Exclusion: Cases with vibration induced arthrosis (M192, M931), polyneuropathy (G622) or mononeuropathy (e.g. carpal tunnel sdr) should not be coded as I730. If several vibration-induced effects are recognised at the same time, the coding should be done according to the most severe of these. A proposition is to rank them as follows: 1. arthrosis, 2 polyneuropathy, 3. mononeuropathy, 4. Raynaud's sdr	I730

SKIN DISEASES

ALLERGIC CONTACT DERMATITIS IRRITANT CONTACT DERMATITIS UNSPECIFIED CONTACT DERMATITIS Inclusion: All recognised cases of contact dermatitis should be included according to their allergic or irritant nature. If separation of allergic and irritant cases is not possible, the code L25X should be used. Please note also the comment concerning contact urticaria. Exclusion: Cases with skin cancer (C44X), precancerous skin lesion (D04X) or ulcerations or chemical burns (not included at all) should not be coded as L23X, L24X or L25X.	L23X L24X L25X
CONTACT URTICARIA Inclusion: Cases recognised for contact urticaria. Note: Some member states may include such cases to allergic contact dermatitis. If most of them do so, all should do it in the data collection.	L506
ACNE	L708

MUSCULOSKELETAL DISEASES

ARTHROSIS OF THE ELBOW Inclusion: All cases recognised for arthrosis of the elbow. Exclusion: Cases recognised for arthrosis of any other joints than elbow or wrist (M931) are not included at all in the data collection.	M192
ARTHROSIS OF THE WRIST Inclusion: All cases recognised for arthrosis of the wrist. (This is not fully according to the ICD-10 code M931 but probably the best solution)	M931
DEGENERATIVE LESIONS OF THE MENISCUS (knee) Inclusion: All cases recognised for meniscal disorders of the knee. Exclusion: Acute knee injuries should not be included in this category. It is preferable to include them in accidents at work.	M232
BURSITIS OF ELBOW	M703
BURSITIS OF KNEE	M704
TENOSYNOVITIS OF THE HAND AND WRIST Inclusion: All cases recognised for tendinitis, tenosynovitis, peritendinitis of the hand or wrist.	M700
MEDIAL EPICONDYLITIS (elbow)	M770
LATERAL EPICONDYLITIS (elbow)	M771

INFECTIONS

A general exclusion for infectious diseases is that cases recognised just for immunity testing, preventive vaccination and any other cases without an infection should be excluded whatever reimbursement was associated. Below are listed 11 infections which are covered by most OD schemes. Many of the national lists, however, mention broad categories like "Infections transmitted from animals", "Infectious diseases in health care and related workers" and "Tropical diseases". Therefore it is not sure which entities are in practice covered. To collect more data on this, it is recoomended to use also the codes mentioned in the list following these 11 codes.

TUBERCULOSIS Inclusion: All cases recognised for tuberculosis in any organ should be included in 15X.	A15X
BRUCELLOSIS Inclusion: All cases recognised for infections caused by *Brucella* species	A23X
ERYSIPELOID	A26X
LEPTOSPIROSIS	A27X
HEPATITIS A	B15X
HEPATITIS B	B16X
HEPATITIS C	B171
HEPATITIS E	B172
OTHER SPECIFIC HEPATITIS	B178
HIV	B24X
ANCYLOSTOMIASIS	B760

CHOLERA, A00X
TYPHOID AND PARATYPHOID FEVER, A01X
SALMONELLOSIS, A02X
SHIGELLOSIS, A03X
OTHER BACTERIAL INTESTINAL INFECTION, A048
AMOEBIASIS, A06X
TULARAEMIA, A21X
ANTHRAX, A22X
TETANUS, A35X
DIPHTERIA, A36X
ERYSIPELAS, A46X
BORRELIOSIS, A692
ORNITHOSIS, A70X, i.e. Avian chlamydiosis
Q FEVER, A78X
RICKETTSIOSIS, A79X
POLIOMYELITIS, A80X
RABIES, A82X
HAEMORRHAGIC FEVER, A988
VARICELLA, B01X
MEASLES, B05X
RUBELLA, B06X
MUMPS, B26X
DERMATOPHYTOSIS, B358
MALARIA, B54X

CODING OF THE TOXIC AND IRRITANT EFFECTS

The coding of acute, subacute and chronic toxic and irritant effects of chemicals is complicated. Cancers, asthma, allergic rhinitis, chronic bronchitis, polyneuropathy, toxic encephalopathy and contact dermatitis have been explained above. The remaining disorders, i.e. haematological, some neurological, some respiratory, hepatic, gastrointestinal and nephrological effects could ideally be separated. According to the pilot data the number of such cases is very low. The following codes could be used, but the questionnaire data (see annex 2) indicate that it may prove difficult for many member states to distinguish between these outcomes as they are coded according to causative agent without too much classification according to the medical diagnosis.

HAEMOLYTIC ANAEMIA, D59X
ANAEMIA, 64X
SECONDARY THROMBOCYTOPENIA, D685
AGRANYLOCTOSIS AND NEUTROPENIA, D70X
BRONCHITIS (ACUTE) OR PNEUMONITIS, J680
PULMONARY OEDEMA, J681
UPPER RESPIRATORY INFLAMMATION, J682
REACTIVE AIRWAYS DYSFUNCTION SYNDROME, J683
PULMONARY FIBROSIS, J841
TOXIC LIVER DISAESE, K71X
TUBULO-INTERSTITIAL KIDNEY DISEASES, N14X
CHRONIC RENAL FAILURE, N18X
COLIC AND OTHER GASTROINTESTINAL SYMPTOMS, R10X

For recognised cases of toxic effects which can't be specified with the above codes, the following codes can be used (the coding of the causative agent is handled by a separate variable, if this variable is detailed enough, only the last code below, i.e. T65X, is needed):

TOXIC EFFECT OF ALCOHOL, T51X
TOXIC EFFECT OF ORGANIC SOLVENTS, T52X
TOXIC EFFECTS OF HALOGEN DERIVATIVES OF ALIPHATIC AND AROMATIC HYDROCARBONS, T53X
TOXIC EFFECT OF CORROSIVE SUBSTANCES, T54X
TOXIC EFFECT OF SOAPS AND DETERGENTS, T55X
TOXIC EFFECT OF METALS, T56X
TOXIC EFFECT OF OTHER INORGANIC SUBSTANCES, T57X
TOXIC EFFECT OF OTHER GASES, FUMES AND VAPOURS, T59X
TOXIC EFFECT OF PESTICIDES, T60X
TOXIC EFFECT OF OTHER AND UNSPECIFIED SUBSTANCES, T65X

POSSIBLE EXTENSIONS OF THE CODE LIST

The following codes represent entities which are either rare as occupational diseases or very heterogeneously dealt in the national lists (see questionnaire in annex 2). Their inclusion in the data collection may be discussed, but the degree of comparability is questionable.

MONONEUROPATHIES
Other lesions of the median nerve, G561
Lesion of the ulnar nerve, G562
Lesion of the radial nerve, G563
Lesion of the lateral popliteal nerve, G573
Tarsal tunnel syndrome, G577

OTHER NEUROLOGICAL DISEASES
Secondary parkinsonism, G212
Amyotrophic lateral sclerosis, G122
Intentional tremor, G252
Epilepsy, G40X
Disorders of the trigeminal nerve, G50X

EYE DISORDERS
Conjunctivitis, H10X
Exclusion: Cases which are at the same time recognised for conjunctivitis and allergic rhinitis or conjunctivitis and asthma, should be coded only as allergic rhinitis and asthma, respectively.

RARE PNEUMOCONIOSES
Aluminosis, J630
Bauxite fibrosis of lung, J631
Beryllosis, J632
Graphite fibrosis of lung, J633
Siderosis, J634
Stannosis, J635

DISEASES NOT PRESENTED ABOVE

There are numerous diagnostic entities which are recognised as occupational diseases in some of the member states, see annex 2 for details. The above list contains those entities which are recognised by most of them. The following exclusions have been made:

Some cancers.
Some infections.
Back pain and related disorders (open list only, not at all or as accidents in most member states)
Neck pain and related disorders (open list only, not at all or as accidents in most member states)
Shoulder pain and related disorders (open list only, not at all or as accidents in most member states)
Mental and behavioural disorders (not at all included in the recognition practice in most member states)

PART 2 - RESULTS OF THE QUESTIONNAIRE ON NATIONAL RECOGNITION CRITERIA AND ASSESSMENT OF SEVERITY OF DISEASE

EUROPEAN STATISTICS ON OCCUPATIONAL DISEASES
EODS phase 1

Questionnaire to Member States

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INTRODUCTION

The evaluation of the EODS (European Occupational Diseases Statistics) 1995 pilot data revealed several problems in comparability of national statistical data on occupational diseases (OD). Consequently it was decided that more detailed data should be collected on the national recognition criteria and assessment of severity of disease. The main objective of the questionnaire was to provide detailed background information for the planning of the next EODS data collection. The results of the questionnaire were collected for two purposes: (1) to plan the next data collection in a way that would maximise the comparability of the data collected and (2) to document the similarities and the differences of the national systems. The draft of the questionnaire was planned by the Finnish Institute of Occupational Health and it was modified according to the comments of the national delegates in the EODS Technical subcommittee meeting on November 3, 1999. The filled questionnaires were returned to Eurostat by the end of December 1999.

The specific aims of the questionnaire were:

1. To clarify the general role of the national OD compensation schemes in the national social security systems in general.
2. To clarify the national recognition criteria of specific ODs
3. To clarify the national practices of assessing the severity of disease in order to find levels above which a reasonable comparability exists.

The first part of the questionnaire (questions 1-26) addresses the general items and the second part (questions 27-197) the disease-specific issues. The disease-specific part of the questionnaire is systematically categorised according to the medical diagnosis to avoid problems which arise when disease and agent-based classifications are mixed. At the end of the questionnaire questions concerning the anticipated changes and alternative systems were included (questions 198-199).

The questionnaire refers to the occupational disease (OD) compensation schemes which were used for collection of data in the EODS pilot study. The questionnaire was sent to the national bodies which participated in the EODS pilot data. The names and affiliations of the respondents are given in appendix 1, but many of the member states also consulted other experts of their national system for some of the answers. In general the respondents were guided to consider their answers according to the current situation (November-December 1999) in the compensation scheme and according to the typical/usual situation in the national system, and not to pay too much attention to rare exceptions or extreme cases. A short glossary was included to specify some key terms (see appendix 2.). In some of the questions abbreviations of the member states are used, these are explained in appendix 3.

The questionnaire was not answered by Greece. In The Netherlands there is no separate recognition system for ODs and the answers refer to the national reporting scheme of ODs and aspects of the normal social security are described in some of the questions. The Swedish Work Injury Insurance Scheme can compensate any disease that reduces the victim's capacity of gainful occupation and there is no national list of occupational diseases. Therefore the Swedish National Social Insurance Board only provided answers for the general questions 1-26.

The questions, the alternatives given and the national answers are summarised for each question of the questionnaire.

GENERAL

1. Which one of the following best describes the situation in your country:

Patients with an occupational disease receive just the normal social security benefits from the normal social security scheme

Luxembourg, The Netherlands

Note: If the disease causes invalidity, the invalidity and occupational disease supplements are cumulative in Luxembourg

Patients with an occupational disease receive the same level of benefits as from the normal social security, but the benefits are paid by a separate system

None of the member states

Patients with an occupational disease receive their main benefits (e.g. pension) from the normal social security system, and some additional benefits from the occupational disease compensation scheme

Denmark, Germany, Ireland, Sweden, United Kingdom

Patients with an occupational disease receive a higher level of benefits than from the normal social security and all the benefits are paid by a separate system

Austria (AUVA), Belgium, Finland, France, Spain, Portugal

Other

In Italy the compensation is paid by a separate system and the level of benefits differs from that of the normal social security.

2. Which of the following benefits are included in your compensation scheme for occupational diseases ? Choose all which are included

	B	DK	D	E	F	IRL	I	L	A	P	FIN	S	UK
Daily allowance or related benefit for temporary sick leave	+		+	+	+	+	+	+		+	+		
Daily allowance or related temporary benefit during retraining for a new job, because it was not possible to continue with the work due to an occupational disease	+		+	+		+	a				+		
Partial daily allowance or related temporary benefit for someone who has to change job temporarily due to an occupational disease, and can't reach the same level of income in the new job as in the previous job	+									+	+		
Full pension for a person who is permanently unable to continue with any work due to an occupational disease	+			+	+	+	+	+	+	+	+	+	
Partial pension for a person who is permanently unable to continue with any work, but this is due partially to an occupational disease and partially to some other factor	+	+		+	+	+		+		+	+	+	+
Partial pension or related benefit for someone who has to change job permanently due to an occupational disease, and can't reach the same level of income in the new job as in the previous job	+	+	+					+	+	+	+		+
Reimbursement of the costs of medication used due to an occupational disease	+		+	+	+	+	+	+	+	+	+		d
Reimbursement of the costs of medical care due to an occupational disease	+		+	+	+	+	+	+	+	+	+		d
Reimbursement of rehabilitation care due to an occupational disease	+		+	+	+		+	c	+	+	+		d
Reimbursement of the costs of medical examinations which were necessary to establish the diagnosis of an occupational disease	+	+	+	+	+		+		+	+	+		
Reimbursement of the costs of medical examinations which were necessary to establish the absence of an occupational disease which had been suspected			+	+	+		b		+	+	+		
Reimbursement of the costs of medical follow-up of an occupational disease	+		+	+	+	+		+	+	+	+		
Reimbursement of the costs of funerals in case of death due to an occupational disease	+		+	+	+	+	+	+		+	+	+	
Inconvenience allowance for permanent physiological impairment due to an occupational disease or any other compensation for the immaterial personal inconvenience									+	+	+		+
Survivor's pension or some other continuous benefit for the widow whose husband/wife has died due to an occupational disease	+	+	+	+	+	+	+	+	+	+	+	+	+
A lump-sum benefit for a death due to an occupational disease		+	+	+						+			
Other (not mentioned above)	+		+							+		+	

In NL the compensation and social security of occupational and non-occupational diseases are not separated.
a (I) only for silicosis and asbestosis
b (I) only inside INAIL surgeries
c (L) a third party pays the rehabilitation costs for an OD
d (UK) these items are covered by the National Health Service and so are largely free of charge to all UK citizens whatever the cause of their condition
Other: B. transportation costs from abroad (death due to an OD)
D. 1. pension for a non-concrete loss of working capacity due to an OD, 2. retraining to a new job if the person had to quit the former job because of an OD
P. 1. a benefit to cover the attendance of an external person in cases of great disability, 2. additional benefits increasing the monthly pension during certain months
S. an annuity covering income loss due to change of job or disability pension

3. Which of the following "events" related to consequences of OD can you systematically identify separately in your national registry ?

	B	DK	D	E	F	IRL	I	L	A	P	FIN	S	UK
Retirement, full pension	+			+		+	+	+	+	+	+		
Retirement, partial pension	+			+		+	+	+	+	+	+		
Sick-leave	+			+		+	+	+	+	+	+		
An extension of a previous sick-leave	+						+	+	+				
Temporary change of job								+					
An extension of a previous period of temporary change of job													
Retraining, continues with a new job without permanent work disability								+	+				
Retraining, continues with a new job with still some permanent work disability								+	+				
Change in the degree of physiological impairment	+					+		+	+	+	+		
Change in the degree of work disability			+				+		+		+		
Reimbursement of costs of medical examination					+	+	+	+	+				
Reimbursement of costs of medical follow-up					+	+	+	+	+				
Reimbursement of costs of rehabilitation			+		+		+		+				
Reimbursement of costs of medication			+		+	+	+	+	+				
Only reimbursement of costs in general	+			+						+	+		
Death due to an OD	+		+	+	+	+	+	+	+	+	+		+

None of the above events can be identified in the Dutch OD notification scheme. The Dutch notification form asks an answer to the questions: “What advise did you give, to whom, and what measures have been taken ?”:

- more specific investigations in working conditions required;
- further medical investigations required;
- advise to employer: for example temporary change of job, changing working conditions, other work methods, etc.;
- advise to employee: temporary change of job, rest, ergonomic advises, etc.;
- advise to employer and employee: permanent change of job;
- personal protection means;
- wait and see what happens;
- other.

There is nothing registered concerning the degree of disability, period of sickness leave or what so ever in NL.

4. What is the minimum duration of temporary sick-leave which is eligible for compensation from the occupational disease compensation scheme ?

Austria:	AUVA: 3 days, SVB: 14 days, Railways: No limit
Belgium:	private sector: 15 days, public sector: no minimum
Denmark:	compensation for sick leave is not included in the OD scheme
Germany:	no minimum
Finland:	more than 3 days
France:	no minimum
Ireland:	more than 3 days
Italy:	more than 3 days
Luxembourg:	no minimum
The Netherlands:	not applicable (no OD compensation system), employer pays the first year
Portugal:	1 day
Spain:	more than 3 days
Sweden:	not applicable, sick leave is paid by the employer/normal social security
United Kingdom:	not applicable

5. Please consider permanent physiological impairment due to an occupational disease. Is there an index in your national system which would describe solely the physiological impairment caused by the OD not taking any account on the occupation or any possible consequences the disease might have on the earnings of the individual.

No: Belgium, Germany, France, Luxembourg, The Netherlands, Portugal, Spain, Sweden
Yes: Austria, Finland, Denmark, Ireland, Italy (new system), United Kingdom

6. Please consider permanent work disability caused by an occupational disease. Which one of the following best describes your national system ?

Permanent work disability due to an OD is measured in percentages

Austria, Belgium, Denmark, Germany, Finland, France, Ireland, Italy, Luxembourg, The Netherlands, Portugal

Permanent work disability is defined always to be either totally or not at all due to an OD (either 100 % or 0%).

Spain

Other

Sweden: The loss of income due to the OD is compensated

United Kingdom: The ability to work is not considered for an award of an Industrial Injuries Scheme Benefit. There is a supplementary pension which reflects loss of earning capacity, but it is only payable for accidents before 30 September 1990, or diseases which began before that date.

7. When assessing the degree of permanent work disability due to an OD in your national compensation system, which of the following are taken into account (choose all which are used):

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	S	UK
The physiological impairment caused by the OD				+	+	+	+	+	+	+	+	+		
The current occupation of the diseased worker				+	+			+			+	+		
The estimated possibilities to continue with another occupation				+	+				+		+	+		
The concrete loss in the earnings of the individual				+					+			+	+	
The estimated loss in the earnings of the individual				+	+						+	+	+	
Other	+	+	+						+			+		+

Other B: Economic incapacity
DK: see question 9
D: 1. The diminished possibilities in the whole working market because of physiological impairment caused by the OD result in the degree of work disability. 2. When a person has got specific skills, which he/she can not use furtheron because of OD, then the degree of work disability can reach a higher level.
NL The answers refer to the normal social security. Other: The estimated earnings of the individual.
FIN The physiological impairment (i.e. medical severity) is mainly taken into account when deciding whether there is some work disability or not. If there is, the level of work disability is calculated either directly from the loss of earnings or estimated. The estimation is made on "non-medical" basis, i.e. it is mainly juridical.
UK see question 6

8. Do the decision rules of your national system theoretically allow that patients with the same diagnosis and the same degree of physiological impairment will get a different degree of work disability ? (For example because they have different occupations)

No: Austria, Ireland, Italy, Luxembourg
Yes: Belgium, Denmark, Germany, Finland, France, The Netherlands, Portugal, Spain, Sweden, United Kingdom

9. If YES in 8, please specify below:

Denmark:	The injured person's prospects to make his/her living in such work that can reasonably be required of him/her in view of his/her skills, education, age and possibilities of rehabilitation or vocational training.
Germany:	See question 7
Finland:	The level of work disability is calculated either directly form the loss of earnings or estimated
France:	The occupation and the individual's possibilities to continue with it are considered
The Netherlands:	See questions 6 and 7
Portugal:	Because the general instructions of the National Disability Table OD/IW allow to vary the degree of work disability between a minimum and a maximum according to the nature of work and others facts
Spain:	For example occupation is taken into account
Sweden:	Loss of income is taken into account
United Kingdom:	See question 6

10. What is the minimum degree of work disability which is eligible for a pension in your occupational disease system?

Austria:	20%
Belgium:	no minimum
Denmark:	15%
Germany:	20% in general, but 10% if the individual already has 10% or more from another OD or an occupational accidents
Finland:	10%
France:	10%
Ireland:	10%
Italy:	16% (new system)
Luxembourg:	no minimum
The Netherlands:	15%
Portugal:	no minimum
Spain:	33%
Sweden:	more than 1/15, i.e. 7%
United Kingdom:	1% for pneumoconiosis, byssinosis and mesothelioma 20% for occupational deafness 14% for other diseases

11. Does this minimum degree depend on disease ?

No: Austria, Belgium, Denmark, Germany, Finland, France, Ireland, Italy, Luxembourg, The Netherlands, Sweden
Yes: Portugal, United Kingdom

12. Do you pay a lump sum reimbursement for those who have some work disability, but the degree is lower than the limit mentioned in question 10 ?

No: Austria, Belgium, Denmark, Germany, Finland, Portugal, The Netherlands, Portugal, Sweden, United Kingdom
Yes: France, Ireland, Italy, Luxembourg, Spain

13. Please consider an individual already on pension due to his/her age or due to a non-occupational disease. He/she is diagnosed as having an OD, which would in theory make him/her retire if he/she was still working. Do such cases begin to receive their pension from the OD compensation scheme instead of the other pension scheme ?

No: Belgium, Denmark, Germany, France, Italy, Luxembourg, The Netherlands, Sweden, United Kingdom
Yes: Austria, Finland, Ireland, Portugal, Spain

Note : An adjustment is made for the pension in Germany and Luxembourg

14. Please consider an individual already on pension due to his/her age or due to a non-occupational disease. He/she is diagnosed as having an OD, which would in theory cause permanent work disability if he/she was still working. Is there an index in your national system, which would describe, for such cases, the degree of work disability caused by the OD:

No: Belgium, Denmark, Ireland, Luxembourg, The Netherlands, Portugal, Spain, Sweden, United Kingdom
Yes: Austria, Germany, Finland (for physiological impairment), France, Italy

15. Is the value of that index stored into your data system ?

No: Belgium, Denmark, Ireland, Luxembourg, The Netherlands, Portugal, Spain, Sweden, United Kingdom
Yes: Austria, Germany, Finland, France, Italy

16. Consider the medical findings, physiological test etc. which you use for the assessment of the physiological impairment or the work disability caused by the OD. Do you store the original values of the various parameters (e.g. pulmonary function tests, audiometry results, radiological scores, clinical data, etc.) into your data system?

No: Belgium, Denmark, Germany, Finland, France, Italy, The Netherlands, Portugal, Spain, Sweden, United Kingdom
Yes: Austria, Ireland (mostly in paper records), Luxembourg

17. If you don't store them now, would you have access to such data in order to construct pre-defined severity scores from the original measurements in future data collection ?

No: Denmark, Germany, Finland, France, Italy, The Netherlands, Portugal, Spain, Sweden, United Kingdom
Yes: Portugal

18. Do you have a national guideline document which is applied for OD and which defines the average (or exact) permanent degree of physiological impairment associated with given physiological/medical parameters:

No: Belgium, Germany, Ireland, Luxembourg, The Netherlands, Spain, Sweden
Yes: Austria, Denmark, Finland, France, Italy (new system), Portugal, United Kingdom

19. If YES in 18, is this guideline legally binding:

No: Austria
Yes: Finland, France, Portugal, United Kingdom

20. If YES in 18, which physiological/medical parameters are concretely dealt in the above document (e.g. which pulmonary function tests, which clinical findings etc.):

The answers of this question were very variable. Some member states had attached the guidelines in their national language while some gave only a broad idea of the contents.

Austria:	Loss of a body part
Denmark:	Not specified
Finland:	Loss of a body part and other consequences of injuries, certain measures of mental health, various symptoms, various measures of vision, hearing, pulmonary function, cardiorespiratory capacity and dermatological health
France:	Various measures of cardiovascular, dermatological, gastrointestinal, neurological, sensory, mental, nephrological, respiratory and haematological health
Italy:	Various measures of cardiovascular, dermatological, gastrointestinal, neurological, sensory, nephrological, respiratory, haematological and endocrinological health
Portugal:	Pulmonary function tests, tonal audiometer testing etc.
United Kingdom:	Occupational Deafness - sensorineural hearing loss. Chronic Bronchitis & or Emphysema - forced expiratory volume in one second.

21. Do you have a national guideline document which is applied for OD and which defines how the degree of permanent work disability (or a related relevant concept) is defined according to physiological/medical parameters and/or socio-economic or other non-medical parameters:

No: Austria, Belgium, Denmark Germany, Finland, France, Italy, Luxembourg, The Netherlands, Spain, Sweden, United Kingdom
Yes: Ireland, Portugal

22. If YES in 21, is this guideline legally binding:

No: -
Yes: Ireland, Portugal

23. If YES in 21, which physiological/medical parameters (e.g. which pulmonary function tests, which clinical findings etc.) and which non-medical parameters (e.g. working conditions, employment prospects etc.) are mentioned in the guideline ?

Ireland:	The guideline is that the person's physical and mental condition at the date of examination by one of the Department's doctors is compared with a person of the same age and sex whose physical and mental condition is normal.
Portugal:	Pulmonary function tests, degree of hearing loss, availability of another suitable and comparable job at the same Company, etc

24. Consider cases which were reported as suspected ODs to your OD compensation scheme, but were finally not recognised. Which of the following data do you store into your data systems ? Choose all which are stored

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Personal data	+	+	+	+	-	+	+	+	-	-	+	+	-	+
Occupation of the individual	-	-	+	+	-	+	+	+	-	-	+	+	-	-
Economic activity of the employer	-	-	-	+	-	+	+	+	-	-	+	+	-	-
Diagnosis	+	+	+	+	-	+	+	+	-	-	+	+	+	-
(Suspected) Causative agent/Exposure	-	-	-	-	-	-	+	+	-	-	-	+	-	-
Degree of physiological impairment	-	-	-	-	-	+	+	-	-	-	-	-	-	-
Degree of work disability	-	-	-	-	-	-	+	-	-	-	-	-	-	-

25. Consider cases with a previously diagnosed non-occupational disease (e.g. asthma) which is later exacerbated by occupational factors. Are such cases recognised as ODs in your national system ?

No: Finland (or very seldom), Ireland, Italy, United Kingdom
Yes: Austria, Denmark, Germany, France, Luxembourg, The Netherlands, Portugal, Spain, Sweden

No answer: Belgium

26. If YES in 25, can you identify such cases separately from other ODs ?

None of the member states can separate these cases from other ODs.

DISEASE SPECIFIC QUESTIONS

Some of the questions in the following part of the questionnaire address the assessment of disability in specific ODs. The general principles of disability and disease severity assessment have been addressed in questions 5-23. In the following disease-specific questions only the general term disability is used. **If** you have in your national system an index which is a measure of the physiological impairment caused by the OD (see question 5), please answer the following disability-related questions according to that index. In the open boxes you may also outline how the respective measures relate to the evaluation of the degree of permanent work disability in each of the following diseases. **If** the only relevant index to describe the (permanent) severity of disease in your national system is the degree of work disability or a related index (see questions 6-7), please answer the following disability-related questions according to that index.

ASTHMA

27. Please list below all causative agents/exposures which are specifically mentioned in your national list of occupational diseases and are relevant for occupational asthma. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if occupational asthma is not at all recognised in your national system).
28. In addition to the agents/exposures specifically mentioned in your national list, does your national system include a possibility of recognising occupational asthma caused by other agents ?

Austria. The national list mentions obstructive airways disease caused by 1. sensitising agents and 2. chemical-irritative or toxic agents. There is no open system for agents not included in these two broad categories.
Belgium. The national list mentions 18 chemicals or groups of chemicals as well as wood dust, flours, proteolytic enzymes and antibiotics as specific causative agents for OA. There is also a possibility of compensating cases caused by other agents (open system).
Denmark. The national list mentions isocyanates, cobalt, chromium compounds, and asthma (allergic or non-allergic) caused by inhalation of dusts or vapours from a. plants and plant products, b. animals and animal products, c. enzymes, dyes, synthetic resins, medicaments or precursors thereof and d. isocyanates and certain anhydrides of epoxy resins. There is also a possibility of compensating cases caused by other agents (open system) which requires a commission evaluation.
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases, however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Asthma is specifically mentioned under 12 of these.
France. About 80 agents relevant for occupational asthma are mentioned in various tables of the national system. There is also a possibility of compensating cases caused by other agents (open system), but only if the degree of permanent work disability is more than 66,66%.
Germany. The national list mentions obstructive airways disease caused by 1.sensitising agents and 2. chemical-irritative or toxic agents, which have enforced abstention from all activities which have caused or may cause the development, deterioration or reactivation of the disease. In addition some of the specific chemical-defined groups of the list include chemicals which are common causes of asthma (e.g. isocyanates), but these categories cover all diseases and asthma is not specifically mentioned.

Ireland. The national list mentions animals and insects used for the purposes of research, education or in laboratories, flour dusts arising from certain activities, fumes or dusts arising from certain hardening agents, fumes arising from the use of resin as a soldering flux, isocyanates, platinum salts, proteoloytic enzymes, red cedar wood dust. There is no possibility of recognising cases caused by other exposures.
Italy. The national list is organised according to the causative agent (58 items - + silicosis & abestosis - for industry and 27 items for agriculture) and lists specific works or industries, where the exposure to these agents is relevant for recognition. Diseases are not usually specifically mentioned under these, but occupational asthma is specifically mentioned in one item on both lists. There is also a possibility of compensating cases caused by other agents.
Luxembourg. The national list mentions obstructive airways disease caused by 1.sensitising agents and 2. irritative or toxic agents, which have enforced abstention from all activities which have caused or may cause the development, deterioration or reactivation of the disease. There is also a possibility of compensating cases caused by other agents.
The Netherlands. There is no national list of OD. The reporting criteria cite international reviews on causative agents of OA. There is also a possibility to report cases caused by other agents.
Portugal. There are no specific causative agents mentioned in the national list. Cases caused by agents commonly agreed as relevant in the international literature can be recognised.
Spain. The national list mentions animal and vegetal products and certain chemicals, which are relevant in some 16 activities. I.e. several combinations of agent and activity are mentioned. In addition some of the specific chemical-defined groups of the list include chemicals which are common causes of asthma, but these categories cover all diseases and asthma is not specifically mentioned. There is also a possibility of compensating cases caused by other agents (open system), which requires a commission evaluation..
United Kingdom. The national list mentions the same agents as Ireland above and in addition 16 other agents or groups of agents. There is also a possibility of recognising cases caused by any other sensitising agent.

29. Please explain below the general recognition criteria which you use for occupational asthma. If relevant please specify any absolute requirements regarding medical investigations needed, severity of disease, duration of exposure, latency time since exposure, any differences concerning recognition of cases with and without evidence of allergic sensitisation to the causative agent, and possible differences concerning recognition criteria of cases caused by agents specifically mentioned in your national list and agents outside of the list.
The answers to this question were very heterogeneous in the level of details and are not presented.

30. When assessing the disability due to occupational asthma, which of the following parameters are taken into account in your national system ? Choose all those which are used
31. Which of the parameters in question 30 is the main determinant of the degree of disability in your country ?

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
FEV1 before bronchodilatation test	++	+		+		++	++	+		++	++	+	
FEV1 after bronchodilatation test		+		+		++	++	+		++	++	+	
Bronchial hyperresponsiveness	++	+		+	+	++	+	+			++	+	
Need of medication		++		+						++		+	
Symptoms at work		++		+				+		++	++	+	
Day-time symptoms (outside of work)		++		+						++		+	
Night-time symptoms (outside of work)		++		+						++		+	
The worker's possibilities to avoid further exposure		+		+				+			++		
Other			++	+					+	++		+	+

+ = is used, ++ = is the main parameter
Other

D. In order to objectify and quantify the pulmo-cardiac effects, it is necessary to carry out functional tests such as whole-body plethysmography, spirography, blood-gas analysis and ergometry. For the purposes of functional analysis, tests on the subject at rest should involve parameters of obstructive ventilation disorder, respiratory distribution disorder and pulmonary emphysema, and parameters of restrictive ventilation disorder and respiratory gas exchange disorder. In addition, examinations under ergometric load enable conclusions to be drawn as to a possible pre-existing restriction of broncho-pulmonary and/or cardiovascular capacity.
E. Peak expiratory flow, Skin test, specific bronchial responsiveness test
NL. All parameters may be considered.
A. Amount of medication used.
FIN. Peak expiratory flow follow-up.
UK. Any or all of the above may be taken into account. Normally, tests are done by the treating clinicians and then are considered with the claim. DSS only questions the claimants, takes chest radiographs if none are available, and then carries out FEV1 tests with and without bronchodilatation. Symptoms of disability are the most important.

32. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states is described below. Specific adaptations are described in each of the specific diseases.

Austria. The degree of physiological impairment is defined by taking into consideration various clinical findings. Values corresponding to 10 % and 20 % of disability were not given.
Belgium. The degree of disability is a function of the physiological impairment percentage and a socio-economic factor. Therefore the values corresponding to 10 % and 20 % of disability can't be given. The degree of physiological impairment as such is determined by various clinical findings.

Denmark. The physiological impairment is defined by taking into consideration all the relevant findings. In asthma the most important factors are symptoms and the need of medication. Rare symptoms, but need of medication corresponds to 10 % and daily symptoms and need of medication to 25 % of disability. In other respiratory diseases the main determinants are the severity of symptoms and FEV1. No reduction in the physical activities (or FEV1 above 2 litres) corresponds to 5 % of disability and a light ventilatory impairment in exercise (or FEV1 around 1.5 to 2.0 litres) corresponds to 20 % of disability.
Finland. The degree of physiological impairment describes the medical severity of the disease (general inconvenience) and takes into consideration all the relevant clinical findings. This is completely separated form the degree of work disability which is a measure of direct or estimated loss of earnings, i.e. it is calculated on a "non-medical" basis. The degree of physiological impairment is defined by taking into consideration various clinical findings. For a disease with reversible respiratory impairment (asthma) a degree of 10 % is given if the symptoms are rare and they can usually be avoided by avoiding harmful exposures and there is no continuous need of medication. A degree of 20 % is given if there are regular day-time symptoms, a continuous need of inhaled medication, but the PEF values remain good with the medication. For diseases with irreversible respiratory impairment (pneumoconiosis etc.) the assessment is based on the severity of symptoms and pulmonary function tests. An impairments up to 25 % corresponds to virtually no respiratory symptoms except in extreme physical exertion (but not in walking uphill or climbing upstairs) and FVC (or FEV1) of 65-79 % of predicted or diffusion capacity of 60-74 %.
France. The degree of physiological impairment is defined by taking into consideration various clinical findings. In mild asthma the main factor is the bronchial hyperresponsiveness test. Reversible bronchospasms and a reduction in the cholinergic threshold correspond to 5-10 % of disability. In (mild) pneumoconiosis, a radiographic assessment (10-30 % of impairment) can be made even if there is only a minor respiratory impairment. In any of the respiratory diseases, if there is a measurable chronic respiratory impairment, the degree is at least 10 % and the assessment can be made according to function tests. The degree of disability is between 10 and 40% for the following values (if there is a chronic respiratory impairment): total lung capacity (TLC) 60-80 % of predicted, FEV1 above 1,5 l or 75 % of predicted or PaO2 above 9,3 kPa (70mmHg).
Germany. The degree of disability is defined case by case taking into consideration all the relevant findings. The evaluation is made by medical consultants who can decide on the tests used. The values corresponding to 10 % and 20 % can't be given and assessment takes into account the reduction in the individual's earning capacity.
Ireland. The degree of disability (loss of faculty) depends on the severity of disease and is determined based on results of pulmonary function tests, clinical assessment and symptomathology. The various parameters are in general equally important and there are no set threshold values for 10 % and 20 %. To be considered incapable of work because of the incapacity a 20% loss of faculty must apply. In the case of less than 20% assessments, a gratuity of pension would be payable.
Italy. The degree of disability is defined by taking into consideration various clinical findings and test results. In asthma, 10 % and 20 % of disability correspond to FEV1 values of at least 80 % and 70-79 % of predicted. In other respiratory diseases the following limits are used for 10 % of disability : FVC, FEV1 or DLCO of 74 % predicted and for 20 % of disability : FVC, FEV1 or DLCO of 63 % of predicted.
Luxembourg. The degree of disability is defined by various clinical and test findings and the severity of symptoms. The values corresponding to 10 % and 20 % of disability can't be given.
The Netherlands. There is no national occupational disease compensation scheme. The reporting system doesn't record anything concerning the degree of disability. Under the general social security, the degree of work disability is determined by the quotient of what one (can possibly) earns (earn), taking into account one’s working capacity and labour market conditions, and the earnings at the moment of the onset of the disability. The minimum degree of disability eligible for pension is 15 %.

Portugal. The degree of disability is defined by taking into consideration all the relevant clinical findings, test results and symptomathology. These parameters are usually equally important determinants. A degree of 5-15 % of disability corresponds to FVC and FEV1 above 80 % of predicted, PaO2 above 75 mmHg and PaCO2 below 45 mmHg (at rest). A degree of 16-30 % of disability corresponds to FVC and FEV1 between 60 and 79 % of predicted and PaO2 above 75 mmHg and PaCO2 below 45 mmHg (at rest) and diffusion values between 60 and 69 %. In asthma an increased bronchial hyperresponsiveness equals 5 % and in pneumoconiosis also radiographic findings are considered.
Spain. The degree of disability is defined by taking into consideration all the relevant findings and the main determinants are variable in each case. The values corresponding to 10 % and 20 % can't be given.
United Kingdom. The degree of disability takes into account all the relevant clinical findings and test results as well as the symptomathology. Normally, tests are done by the treating clinicians and then are considered with the claim. Department of Social Security doctors only question the claimants, take chest radiographs if none are available, and carry out simple pulmonary function tests. Severity of symptoms is the main determinant. The values corresponding to 10 % and 20 % of disability can't be given. A benefit is payable for 1 % or more for pneumoconiosis, byssinosis and mesothelioma and for 14 % or more in other respiratory diseases.

Case 1. Consider the following case of occupational asthma. The patient is a 30-year old spray painter and has isocyanate asthma that fulfils the recognition criteria used in your country. He could not continue with his occupation, but has been moved to another department in the same company, and is no more exposed to isocyanates. Currently he has no night-time asthma symptoms, but has occasional day-time symptoms and has to use regular inhaled corticosteroids and occasionally additional inhaled bronchodilatators. There has been no need of oral corticosteroids. He has a FEV1 (forced expiratory volume in one second) value of 78 % of predicted before bronchodilator, and 86 % after bronchodilatation test. Increased bronchial hyperresponsivness remains (a positive reaction in the histamine provocation test at a dose of 0.30 mg/ml).

33. What would be the current degree of disability of case 1 in your national system ?

Austria:	20-30%
Belgium:	10 % + a socio-economic percentage
Denmark:	10 %
Germany:	not possible to answer
Finland:	20 %
France:	15 %
Ireland:	5-10 %
Italy:	16-20 %
Luxembourg:	not possible to answer, degrees fixed by medical experts
The Netherlands:	not possible to answer, data on earnings needed
Portugal:	5-15 % depending on the severity of symptoms
Spain:	not possible to answer
United Kingdom:	not possible to answer

34. Comments for case 1. If you were not able to answer question 33, please explain why.
The comments are integrated to the table above.

Case 2. Consider the following case of occupational asthma. The patient is a 51-year old baker/confectionery worker. She has an occupational asthma due to wheat flour fulfilling the recognition criteria used in your country. She was employed by a small bakery and due to persistent and severe asthma symptoms it was impossible for her to continue with her work with the same employer.

35. In your national system, which of the following is the most probable solution:

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
She will get a pension due to an OD	+	+		+		+	+	+			+	+	
She will be re-educated, costs covered by the OD system	+	+	+					+	+*			(+)	
She will get a benefit for the permanent work disability due to an OD, but has to find a new job by her own or remains unemployed	+	+			+			+			+		
She will get a benefit for the permanent work disability due to an OD, and gets a pension from the normal social security		+											
Other									+	+			+

* The re-education costs will be covered by the employer/social security

Other A. The choice between re-education and pension depends on the insurance years
NL. During the first year of re-education the employer has to cover the costs. If it becomes clear that it is unreasonable to expect that the employer can provide suitable work, the responsibility for rehabilitation goes to the social insurance company. If she after one year is still without earnings, she will receive a disability benefit for covering the loss of earnings because of her illness. The disablement benefit covers max. 70 % of her last income for a short period of time (depending on her age) and max 70 % of a constructed day salary depending on age. If the disablement benefit only covers part of her former income, she is entitled to an additional unemployment benefit.
UK. She will get a pension related to her disability which does not reflect her inability to work (unless her symptoms began before 30 September 1990 when she will be entitled to a supplementary award of benefit related to but not replacing her loss of wages). She will have to find a job on her own or remain unemployed. It is impossible to say, but if it was felt that her continuing asthma would not have been present without the history of exposure to flour, she would continue to receive an award based upon her continuing symptoms.

Consider that case 2 follows the option you chose in question 35 and is not anymore exposed to wheat flour. She has occasional night-time asthma symptoms and more or less regular day-time symptoms, uses regular inhaled corticosteroids and bronchodilatators, but there has been no need of oral corticosteroids. The basal FEV1 value is 65 % of predicted and improves to 75 % after bronchodilatation. There is a positive reaction in the histamine provocation test at a dose of 0.30 mg/ml.

36. What would be the degree of disability of case 2 in your national system ?

Austria:	40% (at least)
Belgium:	20 % + a socio-economic percentage
Denmark:	25%
Germany:	not possible to answer
Finland:	30%
France:	50%
Ireland:	20-25%
Italy:	21-27%
Luxembourg:	not possible to answer, degrees fixed by medical experts
The Netherlands:	not possible to answer, data on earnings needed
Portugal:	16-30% depending on the severity of symptoms
Spain:	not possible to answer
United Kingdom:	not possible to answer

37. Comments of case 2. If you were not able to answer questions 35-36, please explain why.
The comments are integrated to the table above.

RHINITIS

38. Please list below all causative agents/exposures which are specifically mentioned in your national list of occupational diseases and are relevant for occupational rhinitis. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if occupational rhinitis is not at all recognised in your national system).
39. In addition to the agents/exposures specifically mentioned in your national list, does your national system include a possibility of recognising occupational rhinitis caused by other agents ?

Austria. The answer is not specified but reference is made to the national list.
Belgium. The same causative agents apply as for occupational asthma and there is also an open system.
Denmark. The national list mentions chromium compounds and allergic rhinitis caused by inhalation of dusts or vapours from a. plants and plant products, b. animals and animal products, c. enzymes, dyes, synthetic resins, medicaments or precursors thereof and d. isocyanates and certain anhydrides of epoxy resins. There is also a possibility of compensating cases caused by other agents (open system).
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases, however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. (Allergic) Rhinitis is specifically mentioned under 10 items.
France. About 70 agents relevant for occupational rhinitis are mentioned in various tables of the national system. In practice there is no possibility of compensating cases caused by other agents, because the degree of permanent work disability is never more than 66,66 %.
Germany. The national system recognises cases caused by sensitising agents.
Ireland. Rhinitis is not mentioned in the national list, but could be recognised under "Inflammation or ulceration of the mucous membrane of the upper respiratory passages or mouth produced by dust or liquid or vapour. There is no open system.
Italy. There are no causative agents specifically mentioned for rhinitis. It is recognised outside of the list in the open system.
Luxembourg. The national list mentions obstructive airways disease caused by sensitising agents, which have enforced abstention from all activities which have caused or may cause the development, deterioration or reactivation of the disease. There is also a possibility of compensating cases caused by other agents.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". There is also a possibility to report cases caused by other agents.
Portugal. Rhinitis is not mentioned in the national list, but as the system is open, cases be recognised if 1. There is exposure to a relevant causative agent and 2. The clinical and occupational history of the patient is relevant and 3. There is a positive rhinomanometry.
Spain. The national list mentions "respiratory tract irritation caused by exposure to dusts, liquids, gases and vapours", but rhinitis is not specifically mentioned. Cases of rhinitis can be recognised according to a case by case assessment but they can also be recognised as accidents as work.

United Kingdom. The same causative agents are listed as for occupational asthma. There is no possibility of recognising cases caused by other agents.

40. Please explain below the general recognition criteria which you use for occupational rhinitis. If relevant please specify any absolute requirements regarding medical investigations needed, severity of disease, duration of exposure, latency time since exposure, any differences concerning recognition of cases with and without evidence of allergic sensitisation to the causative agent, and possible differences concerning recognition criteria of cases caused by agents specifically mentioned in your national list and agents outside of the list.
The answers to this question were very heterogeneous in the level of details and are not presented.

41. When assessing the disability due of occupational rhinitis, which of the following parameters are taken into account in your national system ? Choose all those which are used
42. Which of the parameters in question 41 is the main determinant of the degree of disability in your country ?

	B	DK	D	E	F	IRL	I	L	NL*	A	P	FIN	UK
Need of medication		++				+	+					+	+
Symptoms at work	+	++			+*	+	+	+			+	+	+
The worker's possibilities to avoid further exposure		+						+			+	+	+
Other	+												

* Symptoms in general are considered

Other

B. Nasal dyspermeability, nasal septal perforation, problems of smell, nasal bleeding and various other symptoms

NL. All these parameters may be taken into account, depending on the individual case. None are obligatory.

43. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Austria. No values given.
Belgium. Reference values can't be given.
Denmark. No fixed parameter values for 10 and 20 % disability can be given, but the degree is usually around 5-10 %.
Finland. If there is a permanent need of medication, the degree is usually set at 10 %. The degree of work disability is influenced by the difference (concrete or estimated) in the level of income before and after the diagnosis
France. The degree of disability is defined by symptoms and will always be less than 10 %.
Germany. Reference values can't be given and assessment takes into account the reduction in the individual's earning capacity.
Ireland. Reference values can't be given.
Italy. The assessment of the degree of disability is not described, but the value is usually never above 3 %.
Luxembourg. Reference values can't be given.

The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases. Reference values of the social security can't be given, because socio-economic factors are also considered.
Portugal. Symptoms at work is the main determinant. The values are around 10-20 %.
Spain. The general disability assessment can't be described.
United Kingdom. The assessment is made case by case and reference values can't be given.

ALLERGIC ALVEOLITIS (HYPERSENSITIVITY PNEUMONITIS)

44. Please list below all causative agents/exposures which are specifically mentioned in your national list of occupational diseases and are relevant for occupational allergic alveolitis. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if occupational allergic alveolitis is not at all recognised in your national system).
45. In addition to the agents/exposures specifically mentioned in your national list, does your national system include a possibility of recognising occupational allergic alveolitis caused by other agents ?

Austria. The answer is not specified but reference is made to the national list. There is a possibility to recognise cases caused by other agents.
Belgium. Allergic alveolitis is mentioned as one of the items of the national list, no causative agents are specified.
Denmark. Allergic alveolitis is mentioned in the national list under lung diseases caused by certain organic materials (fungal spores, animal protein etc.). An open system exists.
Finland. The occupational disease system is open. The ordinance on occupational diseases, however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Allergic alveolitis is specifically mentioned under the item Spores released by bacteria and moulds and other biologically active substances.
France. About 30 agents relevant for allergic alveolitis are mentioned in various tables of the national system. There is also a possibility of compensating cases caused by other agents (open system), but only if the degree of permanent work disability is more than 66,66 %.
Germany. Allergic alveolitis is mentioned in the national list, no causative agents are specified.
Ireland. The national list mentions extrinsic allergic alveolitis (including farmer's lung) due to any occupation involving exposure to moulds or fungal spores or heterologous proteins by reason of employment in: agriculture or horticulture, forestry or cultivation of edible fungi or maltworking or loading or unloading or handling in storage mouldy vegetable matter or edible fungi, or carrying for or handling birds or handling bagasse. There is no open system.
Italy. Both the industrial and agricultural national list mention allergic alveolitis caused by exposure to moulds, plant dusts, animal dusts and chemicals. An open system exists
Luxembourg. The national list mentions allergic alveolitis caused by organic dusts.
The Netherlands. There is no national list of OD . The reporting criteria are based on "Information notices on diagnosis of occupational diseases. There is also a possibility to report cases caused by other agents.
Portugal. The national system is open. The national list mentions allergic alveolitis caused by cork, wood, beryllium and related compounds, copper sulphate, cotton, cement, pesticides, grain dust and wheat.
Spain. The national list doesn't mention allergic alveolitis. Such cases can be recognised according to a case by case assessment but they can also be recognised as accidents at work.

United Kingdom. The national list mentions allergic alveolitis caused by exposure to moulds or fungal spores or heterologous proteins by reason of employment in A. agriculture, horticulture, forestry, cultivation of edible fungi or malt-working; or, B. loading or unloading or handling in storage mouldy vegetable matter or edible fungi; or, C. caring for or handling birds; or D. handling bagasse. There is no open system.

46. Please explain below the general recognition criteria which you use for occupational allergic alveolitis. If relevant please specify any requirements regarding medical investigations required, severity of disease, duration of exposure, latency time since exposure, any differences concerning recognition of cases with and without evidence of allergic sensitisation to the causative agent, and possible differences concerning recognition criteria of cases caused by agents specifically mentioned in your national list and agents outside of the list.
The answers to this question were very heterogeneous in the level of details and are not presented.

47. When assessing the permanent disability due to allergic alveolitis, which of the following parameters are taken into account in your national system ? Choose all those which are used
48. Which of the parameters in question 47 is the main determinant of the degree of disability in your country ?

Parameter	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
FVC						+	+	++		+	+		
VC	+	+			+			++		++	+		
FEV1		+			+	+	+	++		+	+		
Diffusion values	++	+				+	+	+		+	+		
Blood gas analyses	+	+			+		+	+		++	+		
Exercise testing		+						+		+	+		
Radiographic severity of the disease		+				+		+		++	+		
Severity of symptoms		+				+		+		++	+		
The worker's possibilities to avoid further exposure		+											
Other		+			+				+	+			

+ = is used, ++ = is the main parameter

Other DK. General clinical condition and smoking habits
F. Signs of hypertrophy of the right hearth
NL. All these parameters may be taken into account, depending on the individual case. None are obligatory.
UK. Any or all of the above may be taken into account. Normally, tests are done by the treating clinicians and then are considered with the claim. DSS only questions the claimants, takes chest radiographs if none are available, and then carries out FEV1 tests with and without bronchodilatation. Symptoms of disability are the most important.

49. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

BYSSINOSIS

Dusts from cotton, flax and related plants can cause a respiratory syndrome which is commonly called as byssinosis.

50. Is such a syndrome mentioned in your national list of occupational diseases ?

No: Spain *, Portugal**
Yes: Austria, Belgium, Denmark, Germany, Finland, France, Ireland, Italy, Luxembourg, The Netherlands ***, United Kingdom

* Can be recognised as asthma because exposure to cotton dust is specified as a causative agent for asthma in the national list.
** The system is open. Byssinosis is not specifically mentioned in the national list
*** There is no national list of OD. Byssinosis is included in the reporting guidelines.

51. When assessing the permanent disability due to byssinosis, which of the following parameters are taken into account in your national system ? Choose all those which are used
52. Which of the parameters in question 51 is the main determinant of the degree of disability for byssinosis ?

Parameter	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
FVC							++	++		++	+	+	
VC		+			+			++		+	+	+	
FEV1	++	+			++		++	++		+	+	+	
Diffusion values		+					++	+		+	+	+	
Blood gas analyses		+			++		+	+		+	+		
Exercise testing		+						+		+	+		
Radiographic severity		+						+			+		
Severity of symptoms		+											
Other	+	+	+		+	+			+	++			+

+ = is used, ++ = is the main parameter

Other

B. Bronchial hyperreactivity
DK. General clinical condition and smoking habits
D. A major precondition is the targeted recording of the pathological and occupational case history, whereby special attention should be paid to portraying the onset of the disorder, with the typical "Monday symptoms". These symptoms also make it easier to exclude the possibility of allergic bronchial asthma. In contrast to the latter, in cases of byssinosis, at least in the early stages, and even if exposure continues during the working week, there is a reduction in the symptoms. Chronic bronchitis, pulmonary emphysema and hypertrophy of the right heart often have other causes. It must be carefully checked whether there is any causal link with the specific exposure. Permanent impairment of general physical capacity does not normally occur until stage III of byssinosis. Investigations of respiratory and cardiovascular functions must be carried out, inter alia to check whether there are restrictive or obstructive ventilation disorders or chronic cor pulmonale, and generally provide an adequate basis for assessment.
IRL. The claimant would usually be referred to a pulmonary physician for free pulmonary function tests and clinical assessment.

NL All these parameters may be taken into account, depending on the individual case. None are obligatory.
A. Lavage, specific inhalation challenge, body pletysmography and "monday symptoms"
UK. Any or all of the above may be taken into account. Normally, tests are done by the treating clinicians and then are considered with the claim. DSS only questions the claimants, takes chest radiographs if none are available, and then carries out FEV1 tests with and without bronchodilatation. Symptoms of disability are the most important.

53. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

CHRONIC BRONCHITIS

54. Please list below all causative agents/exposures which are specifically mentioned in your national list of occupational diseases and are relevant for occupational chronic bronchitis (i.e. chronic obstructive pulmonary disease). Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if occupational chronic bronchitis is not at all recognised in your national system).
55. In addition to the agents/exposures specifically mentioned in your national list, does your national system include a possibility of recognising occupational chronic bronchitis caused by other agents ?

Austria. The answer is not specified but reference is made to the national list.
Belgium. Chronic bronchitis is not on the national list.
Denmark. The national list mentions vanadium and its compounds. In addition the list includes "Chronic bronchitis caused by several years of heavy exposure to unspecified dusts, including dusts from insulating material; grain, feedstuffs, wood working dust as well as fumes from welding and desurfacing" The item refers also to modest consumption of tobacco. The system is open.
Finland. The occupational disease system is open. The ordinance on occupational diseases, however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Chronic bronchitis is specifically mentioned under Arsenic and its compounds.
France. The national list mentions (Chronic respiratory manifestations) coal (coal mining), iron (mining), methyl metacrylate and plant derived textile dusts. In farmers, the list mentions, all respiratory allergy provoking dusts and plant derived textile dusts.
Germany. The national list mentions fine dust in coal mining. The system is open for other irritants.
Ireland. Chronic bronchitis is not on the national list. There is no open system.
Italy. The national list mentions four industries which are relevant for chronic bronchitis.
Luxembourg. The national list mentions allergic agents and chemical irritants and toxic agents.
The Netherlands. There is no national list of OD . The reporting criteria are based on "Information notices on diagnosis of occupational diseases". There is also a possibility to report cases caused by other agents.

Portugal. Chronic bronchitis is not on the national list.
Spain. The national list mentions hard metals, talc and slags. The national list mentions also "respiratory tract irritation caused by exposure to dusts, liquids, gases and vapours, but chronic bronchitis is not specifically mentioned. Cases can be recognised according to a case by case assessment but they can also be recognised as accidents at work.
United Kingdom. The national list (Chronic bronchitis and emphysema) mentions coal dust by reason of working underground in a coal mine at least 20 years. The system is open for other agents.

56. When assessing the permanent disability due to chronic bronchitis, which of the following parameters are taken into account in your national system ? Choose all those which are used
57. Which of the parameters in question 56 is the main determinant of the degree of disability for chronic bronchitis ?

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
FVC							+	++		++			
VC		+			+			++		+			
FEV1		+			++		++	++		+		+	
Diffusion values		+					+	+		+			
Blood gas analyses		+			++		+	+		+			
Exercise testing		+						+		+			
Radiographic severity		+						+		+			
Severity of symptoms		+								++		+	
Other		+	+	+	+				+	++		+	+

+ = is used, ++ = is the main parameter

Other

DK. General clinical condition and smoking habits
D. Bronchial mucus may contain pathogenic germs. However, bronchial diseases which are primary infections and those which are of allergic origin must be excluded. There is evidence of a predominantly infectious cause if there is recurrent sinusitis over a number of years. Mainly allergic obstructive bronchial disorders are observed as bronchial asthma or asthmoid bronchitis when there is sensitivity to ubiquitous environmental allergens, e.g. pollen, house mites or animal hair. Attention should also be drawn to the possible presence of an obstructive respiratory disorder caused by chemical irritants or toxic or allergenic agents (cf. Nos 4302, 4301 and 1315). It is also important to exclude the possibility of bronchial carcinoma. Silicosis with broncho-pulmonary consequences (bronchitis, pulmonary emphysema) comes under No. 4101 or 4102.
E. All these parameters could be used for diagnosis establishment. But there is no standardised guide for diagnosis. In most cases, that depends on physician's criteria.
A. Need of medication, body-pletysmography.
NL All these parameters may be taken into account, depending on the individual case. None are obligatory.
FIN. Peak expiratory flow follow-up. There are very few cases.
UK. Any or all of the above may be taken into account. Normally, tests are done by the treating clinicians and then are considered with the claim. DSS only questions the claimants, takes chest radiographs if none are available, and then carries out FEV1 tests with and without bronchodilatation. Severity of symptoms is the most important.

58. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

ACUTE IRRITANT RESPIRATORY EFFECTS

59. Various chemicals may cause acute irritation of the respiratory tract ranging from rhinitis to pulmonary oedema. Can such conditions be recognised as occupational diseases in your national system ?

No: Germany, Italy (only as accidents), Portugal (only as accidents)
Yes: Austria, Belgium, Denmark, Finland, France, Ireland, Luxembourg, The Netherlands, Spain, United Kingdom

60. Which of the following conditions can be recognised as occupational diseases caused by irritants in your national system (do not consider allergens here). Choose all which are recognised

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
Acute rhinitis	+	+	-	-	+	+	-	+		-	-	+	+
Chronic rhinitis	+	+	-	-	+	+	-	+		-	-	+	+
Acute laryngitis	-	+	-	-	-	+	-	+		-	-	+	-
Chronic laryngitis	-	+	-	-	-	+	-	+		-	-	+	-
Acute bronchitis	-	+	-	-	+	+	-	+		-	-	+	+
Pneumonitis	+	+	-	-	+	+	-	+		-	-	+	+
Pulmonary oedema	+	+	-	-	+	+	-	+		-	-	+	+
Reactive airways dysfunction syndrome (RADS)	+	+	-	-	+	+	-	+		-	-	+	-
Other	-	-	-	+	-		-	-		+	-	+	+

Many member states had included explanatory notes:

Denmark. Such cases are extremely rare.
Finland. Emphysema is also mentioned. Most of these are not specifically mentioned in the ordinance of OD, which says only irritation of the mucous membranes or respiratory symptoms under many of the chemical categories of the ordinance. Basically the system is open for any disease where there is enough evidence of the causation.
Ireland. These would be considered as occupational accidents due to a short acute exposure episode rather than as OD's.
The Netherlands. If professional judgement leads to the conclusion that in an individual case the disease has an occupational origin, it has to be notified as occupational disease.
Spain. The national list only mentions "respiratory tract irritation caused by exposure to dust, liquids, gases or vapours". The list does not specify the symptoms or medical processes.
United Kingdom. In general, acute irritant effects will be dealt with under the provisions for industrial accidents. However, some of the prescribed diseases include provision for acute irritant effects. They are:-
C18 – poisoning by cadmium – chemical pneumonitis, respiratory failure, cadmium emphysema;

C17 – poisoning by beryllium or compound of beryllium – acute chemical pneumonitis, chronic granulomatous pneumonitis, rhinitis, bronchitis
C15 – poisoning by oxides of nitrogen – laryngo spasm, pneumonia, pulmonary oedema, bronchiolitis.

61. Please explain below how your national system defines which of the irritative respiratory effects are recognised as occupational diseases and which ones as accidents at work.

Denmark. Some are mentioned in the list of OD and are compensated as OD.
Finland. The compensation is run by the same insurance system and the respective legislation do not define the borderline very clearly, so it may not be clear which of these cases are coded as accidents and which as diseases.
France. Occupational disease: prolonged exposure. Accident at work: sudden, unusual exposure
Ireland. Generally speaking, if a person were exposed to a substance for a short period not more than a few hours at most, it would be considered as an accident rather than a disease. However, if the exposure period was longer than this, the substance and corresponding employment would have to be on our list of OD's before the claim could be considered. If the substance and employment were not on our list, claim would be disallowed.
Italy. Acute respiratory effects with a short duration can only be considered accidents at work
The Netherlands. All irritative effects, which are not noticeable immediately after the incident (some hours), are to be notified as occupational diseases. If the irritative effect has to be of clinical importance or lead to impairment or incapacity.
Portugal. Acute respiratory effects with a short duration can only be considered accidents at work
Spain. In general, acute effects due to irritant exposure are recognised as work accidents.
United Kingdom. When a claimant submits a claim for an incident as either an accident or a disease, it is treated as a claim for an industrial disease if the Decision Maker accepts that the incident represents an event which is covered by any of the prescribed diseases. If the Decision Maker decides that it is not so covered, it is then considered under the accident provisions.

HARD-METAL DISEASE

62. Which of the following conditions caused by dusts of hard metals are specifically mentioned in your national list of OD?

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
Our national list mentions only hard metal disease in general	+	+		+			+	+				+	
Hard metal disease is not at all mentioned in the national list						+					+		+
Asthma					+							+	
Rhinitis					+							+	
Pulmonary fibrosis			+		+		+	+		+			
Other					+								

Other

F. Cardiac complications, pulmonary infectious complications, chronic irritative respiratory syndrome
FIN. The ordinance mentions under "Cobalt and its compounds" asthma and rhinitis due to sensitisation to cobalt and in addition it mentions hard-metal disease under the same title.
NL. No OD recognition scheme, reporting according to "Information Notices".
UK. Although hard metal disease is not mentioned specifically, cases where lung fibrosis has been caused will be covered as pneumoconiosis

63. Which of the following conditions caused by dusts of hard metals can you identify as separate entities in your data system ?

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
Asthma	+				+			+				+	
Rhinitis	+				+			+				+	
Pulmonary fibrosis	+		+		+		+	+		+		+	
Other					+								

Other DK. Hard-metal disease is extremely rare in DK
F. See footnote of question 62.
NL. No OD recognition scheme, reporting according to "Information Notices".

SILICOSIS

64. Is silico-tuberculosis recognised as an OD in your national system ?

No: Denmark, Ireland
Yes: Austria, Belgium, Germany, Finland, France, Italy, Luxembourg, The Netherlands, Portugal, Spain, United Kingdom

65. Can you separate cases of silico-tuberculosis from cases of silicosis in your national registry ?

No: Italy, Spain, United Kingdom
Yes: Austria, Belgium, Germany, Finland, France, Luxembourg, The Netherlands, Portugal

66. Is coal-worker's pneumoconiosis recognised as an OD in your national system ?

No: Austria, Denmark (no cases)
Yes: Belgium, Finland (no cases), France, Ireland, Italy, The Netherlands, Portugal, Spain, United Kingdom

In Germany chronic bronchitis and emphysema in coal-miners are considered ODs and pulmonary fibrosis can be compensated as silicosis if silicosis is present.

67. Can you separate cases of coal-worker's pneumoconiosis from cases of silicosis in your national registry ?

No: Austria, Belgium, France, Ireland, Spain, United Kingdom
Yes: Germany (see comment above), Finland (no cases), The Netherlands, Portugal

68. When assessing the permanent disability due to silicosis, which of the following parameters are taken into account in your national system ? Choose all those which are used
69. Which of the parameters in question 68 is the main determinant of the degree of disability for silicosis ?

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
FVC				+		+	++	++		++	+	+	
VC		++		+	++	+		++		+	+	+	
FEV1	++	++		+	++	+	++	++		+	+	+	
Diffusion values	+	+		+		+	++	+		+			
Blood gas analyses	+	+		+	++		+	+		+	+		
Exercise testing		+		+				+		+			
Radiographic severity	++	++		+	++	+	+	++		++	+		
Severity of symptoms		++		+	++	+				+	+	++	+
The worker's possibilities to avoid further exposure to the causative agent		++		+									
Other			+			+			+	+			+

+ = is used, ++ = is the main parameter

Other

D. An indication that there is a suspected case of occupational disease No. 4101 is justified if, in the light of the occupational case history, the X-ray shows round shading (p, q, r) at least to the extent of 1/1. The medical assessment of silicosis, including the radiological low-grade form, is based on the impairment which it causes in lung function and the cardiovascular system. Functional analysis of the lung with the subject at rest and under physical strain is indispensable as objective proof of impairment. Inter alia, chronic obstructive bronchitis, pulmonary emphysema, and increased pressure in pulmonary circulation with cor pulmonale may be the result of silicosis.
IRL. Silicosis is not on the national list of ODs, but is included under the general item of pneumoconiosis
NL. All these parameters may be taken into account, depending on the individual case. None are obligatory.
A. Therapy, amount of medication and body-pletysmography
UK. Any or all of them may be taken into account by the DSS doctor who advises the Decision Maker. In general, DSS doctors will only take a history, take plain chest radiographs if none are available, and carry out simple spirometry themselves.

70. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

ASBESTOSIS AND PLEURAL ASBESTOS-DISEASES

71. When assessing the permanent disability due to asbestosis (pulmonary fibrosis due to asbestos), which of the following parameters are taken into account in your national system ? Choose all those which are used
72. Which of the parameters in question 71 is the main determinant of the degree of disability for asbestosis ?

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
FVC				+		+	++	++		+	+	++	
VC		+		+	+	+		++		+	+	+	
FEV1		++		+	++	+	++	++		+	+		
Diffusion values	++	+		+		+	++	+		++	+	+	
Blood gas analyses	+	+		+	++		+	+		++	+		
Exercise testing		+		+				+		++	+		
Radiographic severity	+	++	+	+	++	+	+	++		++	+		
Severity of symptoms		++		+	+	+				+		++	
The worker's possibilities to avoid further exposure to the causative agent		+		+									
Other	++		+						+	+			+

+ = is used, ++ = is the main parameter

Other

B. Total pulmonary capacity
D. The X-ray result is decisive for the diagnosis. Principally in the sub-pleural area in the lower two-thirds of the lung, mostly with increasing intensity towards the base and the hilus, there are small, irregular (or linear) shadows (ILO classification: s-t-u). They may initially present misty streaks with hairlike features on the edge and later thicken into a net-like multiplication of structures (ILO classification: 1-2-3) going as far as diffuse fibrocystic changes. Horizontal shadowy streaks (Kerley B lines) near the lateral thoracic wall also occur. Sometimes the fibrosis appears particularly clearly along the edge of the heart shadow. In later stages there may be blurring of the cardiac boundaries and the top of the diaphragm, and the upper areas may be more permeable to rays.
NL. All these parameters may be taken into account, depending on the individual case. None are obligatory.
A. Therapy, amount of medication and body-pletysmography
UK. Any or all of them may be taken into account by the DSS doctor who advises the Decision Maker. In general, DSS doctors will only take a history, take plain chest radiographs if none are available, and carry out simple spirometry themselves.

73. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

74. Consider an asbestos-exposed individual (e.g. insulator) who has bilateral diffuse fibrosis of the visceral pleura, but no evidence of pulmonary fibrosis. Can his visceral pleural fibrosis be recognised as an occupational disease in your national system ?

No: Ireland, The Netherlands, Spain
Yes: Austria, Belgium, Denmark, Germany, Finland, France, Italy, Luxembourg, Portugal, United Kingdom

75. If YES in 74: Does your national system consider visceral pleural fibrosis as potentially causing permanent disability to him

No: Austria
Yes: Belgium, Denmark, Germany, Finland, France, Italy, Luxembourg, Portugal, United Kingdom

76. If YES in 75: When assessing the permanent disability due to visceral pleural fibrosis, which of the following parameters are taken into account in your national system ? Choose all those which are used
77. Which of the parameters in question 76 is the main determinant of the degree of disability for visceral pleural fibrosis ?
The answers were similar to those in 71-72 for asbestosis

78. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

79. Consider an asbestos-exposed individual (e.g. insulator) who has bilateral pleural plaques, but no evidence of pulmonary fibrosis or of diffuse fibrosis of the visceral pleura. Can his pleural plaques be recognised as an occupational disease in your national system ?

No: Belgium (only if widespread and with restriction), Denmark, Ireland, The Netherlands, Spain, United Kingdom
Yes: Germany, Finland, France, Italy, Luxembourg, Portugal

80. If YES in 79, does your national system consider pleural plaques as potentially causing permanent disability to him?

No: Finland (very seldom)
Yes: Germany, France (but below 5%), Italy, Luxembourg, Portugal

81. If YES in 80, which of the following parameters are taken into account when assessing the permanent disability due to pleural plaques in your national system ? Choose all those which are used
82. Which of the parameters in question 81 is the main determinant of the degree of disability for pleural plaques ?
The answers were similar to those in 71-72 for asbestosis

83. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

84. Consider a patient with both an asbestos-related disease and COPD-emphysema. Do you consider also the obstructive component (FEV1) of the pulmonary function impairment when assessing the disability ?
These questions were not answered by Germany and Spain

84a. In case of asbestosis and concomitant COPD-emphysema

No:	-
Yes, if there is also a restrictive component:	Belgium, Denmark, Finland, Luxembourg, Portugal, United Kingdom
Yes, regardless of whether there is also a restrictive component:	Austria, France, Ireland, Italy, The Netherlands

84b. In case of bilateral visceral pleural fibrosis and concomitant COPD-emphysema

No:	Austria, Denmark, Finland, Italy
Yes, if there is also a restrictive component:	Belgium, Luxembourg, Portugal, United Kingdom
Yes, regardless of whether there is also a restrictive component:	France

84c. In case of bilateral pleural plaques and concomitant COPD-emphysema

No:	Austria, Belgium, Denmark, Finland, Italy
Yes, if there is also a restrictive component:	Luxembourg, Portugal
Yes, regardless of whether there is also a restrictive component:	France

Case 3. Consider a 60-year old man, who has worked 35 years as a pipe insulator. He was heavily exposed to asbestos in 1960-72 and to a lesser extent in 1973-80. He has an elevated concentration of asbestos bodies in BAL fluid (35 AB/ml). He has chronic cough and exercise dyspnoea. His chest x-ray shows pulmonary fibrosis typical of asbestosis (profusion 1/1 according to ILO classification of pneumoconiosis). Pulmonary function tests show the following values: VC 70 %, FVC 68 % and FEV1 84 % of predicted values. There is also a diffusion impairment (TLco/VA 70 % of predicted).

85. What would be the current degree of disability of this case 3 in your national OD system ?

Austria:	30%
Belgium:	5% + a socio-economic percentage
Denmark:	20 %
Germany:	not possible to answer
Finland:	15-20%
France:	20%
Ireland:	25-30%
Italy:	11%
Luxembourg:	not possible to answer, degrees fixed by medical experts
The Netherlands:	not possible to answer, data on earnings needed
Portugal:	15 % depending on the severity of symptoms
Spain:	not possible to answer
United Kingdom:	not possible to answer because symptoms of dyspnoea are not described

86. Comments of case 3. If you were not able to answer question 85, please explain why.
The comments are given in 85.

OTHER PNEUMOCONIOSES

Asbestosis, silicosis and hard-metal interstitial lung disease are not dealt here

87. Please list below all causative agents/factors which are specifically mentioned in your national list of occupational diseases and are relevant for pneumoconiosis. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if other pneumoconioses are not at all recognised in your national system).

Austria. No specifications were given, but reference was made to the national list.
Belgium. Other silicates, graphite, aluminium and its compounds, Thomasphosphat
Denmark. Other silicates, aluminium and its compounds
Finland. The system is open. Berylliosis is specifically mentioned under beryllium and its compounds
France. Iron oxide
Germany. Aluminium and its compounds, Thomasphosphat
Ireland. Various industries are mentioned in combination with different kinds of silicate-related dusts, aluminium and its compounds, graphite, coal, tin. Any underground work where the aim is getting of any mineral.
Italy. Other silicates, dolomite and related minerals, aluminium and its compounds, iron oxide (siderosis)
Luxembourg. Aluminium and its compounds, Thomasphosphat, nickel and its compounds
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Portugal. Iron, barium, tin, talc and other silicates.

Spain. Other silicates, aluminium and its compounds (cannobinosis and bagassosis)
United Kingdom. Various industries are mentioned in combination with different kinds of silicate-related dusts, aluminium and its compounds, graphite, coal, tin. Any underground work where the aim is getting of any mineral.

88. When assessing the permanent disability due to pneumoconiosis which of the following parameters are taken into account in your national system ? Choose all those which are used
89. Which of the parameters in question 88 is the main determinant of the degree of disability for other pneumoconioses ?
The answers were similar to silicosis (questions 68-69) and asbestosis (questions 71-72)

90. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The general principles of the assessment of the degree of disability in the respiratory occupational diseases for each of the member states are described in question 32.

ASBESTOS-RELATED MESOTHELIOMA

91. Have there been any changes in the national recognition criteria of mesothelioma since the EODS 1995 pilot evaluation (duration/intensity of exposure, histological verification of diagnosis, etc.) ?

No: Belgium, Denmark, Germany, Finland, France, Ireland, Italy, Luxembourg, The Netherlands, Portugal, Spain, United Kingdom
Yes: Austria

92. If YES in 91, please specify below
Austria. No specifications were given, but reference was made to the national list.

93. Is mesothelioma recognised as an occupational disease in your national system, if the diagnosis is made only post-mortem ?

No: Ireland, The Netherlands
Yes: Austria, Belgium, Denmark, Germany, Finland, France, Italy, Luxembourg, Portugal, Spain, United Kingdom

ASBESTOS-RELATED LUNG CANCER

94. Consider a patient with lung cancer who has been exposed to asbestos at work. In which of the following circumstances can lung cancer be recognised as an asbestos-related OD ? Choose all which are applicable

	B	DK	D	E	F	IRL	I	L	NL	A	P	FIN	UK
If the patient has asbestosis (i.e. diffuse pulmonary fibrosis)	+	+	+	+	+	+	+	+			+	+	+
If the patient has bilateral diffuse pleural fibrosis, but no asbestosis	+	+	+		+	+	+				+	+*	+
If the patient has unilateral diffuse pleural fibrosis, but no asbestosis		+	+		+	+	+				+	+*	+
If the patient has bilateral pleural plaques, but no asbestosis		+	+		+	+	+				+	+*	
If the patient has unilateral pleural plaques, but no asbestosis		+	+		+		+				+	+*	
If the patient has a significant exposure history, but no asbestosis or pleural changes	+	+	+		+		+	+		+	+	+	

* If the exposure has been heavy enough

95. Is asbestos-related lung cancer recognised as an occupational disease, if the diagnosis is made only post-mortem ?

No: Ireland, The Netherlands
Yes: Austria, Belgium, Denmark, Germany, Finland, France, Italy, Luxembourg, Portugal, Spain, United Kingdom

96. Consider a case with lung cancer which fulfils your national recognition criteria of asbestos-related disease. The cancer could be cured by surgery (e.g. lobectomy) and the pulmonary function tests after surgery are within normal values. What would be the degree (%) of permanent disability of this case in your national system ?

No answer: Belgium, Denmark, Luxembourg, Spain

Austria. Less than 20%, but controls
Germany. It is not possible to answer
Finland. 50%
France. 70%
Ireland. Some loss of faculty would probably be assessed
Italy. It is not possible to answer
The Netherlands. Not possible to answer because data on earnings is not available
Portugal. Up to 80%
United Kingdom. It is impossible to say. A provisional award would be made to cover the period up to surgery which would largely depend upon symptoms. It is likely that a higher award would be made for a further period to cover the pain and disability associated with surgery and the post-operative period. If the claimant was left fit and well after operation, it is likely that a very low award would be made to cover residual prognostic uncertainty.

OTHER CANCERS

97. Please list below all pairs of cancer (site/type of cancer and causative agent) which are specifically mentioned in your national list of occupational diseases (e.g. sinonasal cancer caused by nickel compounds). Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list. Please list also haematological malignancies.

See Part 6.

98. In addition to the agents specifically mentioned in your national list, does your national system include a possibility of recognising occupational cancer caused by other agents ?

No: Ireland, United Kingdom
Yes: Austria, Belgium, Denmark, Germany, Finland, France, Italy, Luxembourg, Portugal, Spain

The Netherlands: There is no recognition system for ODs, but the reporting system is open.

99. In addition to the cancer sites/types specifically mentioned in your national list, does your national system include a possibility of recognising other cancers ?

No: Ireland, United Kingdom
Yes: Austria, Belgium, Denmark, Germany, Finland, France, Italy, Luxembourg, Portugal, Spain

The Netherlands: There is no recognition system for ODs, but the reporting system is open.

100. When assessing the degree of disability caused by occupational cancer do you automatically apply a minimum degree (other than 0 %) regardless of the actual clinical situation.

No: Austria, Denmark, Germany, Ireland, Italy, Luxembourg, Portugal, United Kingdom
Yes: Finland (50% physiological impairment), France (70%)
No answer: Belgium, Spain

ALLERGIC CONJUNCTIVITIS

101. Please list below all causative agents/exposures which are specifically mentioned in your national list of occupational diseases and are relevant for occupational allergic conjunctivitis. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if occupational allergic conjunctivitis is not at all recognised in your national system).

Belgium. Reference is made to causative agents of asthma (question 27).
Denmark. The disease is not mentioned in the list.

Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Allergic conjunctivitis is specifically mentioned under the following items: Organic dusts and exposures (I.e. flours, grain, wood dusts and materials, animal epithelia, excretions and other exposures of animal origin, dusts of natural fibres and enzymes, natural resins, India rubber)
France. Furfural alcohol, Beryllium and compounds, Wood, Chlorpromazine, Enzymes, Furfural, Organic isocyanates.
Germany. The disease is not mentioned in the list.
Ireland. The disease is not on the list.
Italy. The list doesn't include allergic conjunctivitis. It is a disease outside the list. In such cases the patient must demonstrate the occupational origin of disease.
Luxembourg. Solvents, pesticides and other chemicals, cosmetics, medicines.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". There is also a possibility to report cases caused by other agents
Portugal. There is no positive list of causative agents/exposures which are specifically mentioned in our national list of occupational diseases. The experts are free to recognise as causative agents the ones that are referred and commonly agreed as relevant in the available literature.
Spain. The national list only mentions "respiratory tract irritation caused by exposure to dust, liquids, gases or vapours". Nevertheless, when a case of A.C. is closely associated with an occupational exposure then it could be recognised after a judging process. On the other hand, the first items of the list (chemical exposures) contain some substances which could produce A.C. In such cases, the disease could also be recognised.
United Kingdom. The diseases is only recognised as part of allergic rhinitis

102. In addition to the agents/exposures in your national list, does your national system include a possibility of recognising occupational allergic conjunctivitis caused by other causative agents/exposures ?

No: United Kingdom, Ireland, France (always below 66,66% disability), Germany
Yes: Belgium, Denmark, Finland, The Netherlands, Portugal (see 101), Spain

103. Please explain below the general recognition criteria which you use for occupational allergic conjunctivitis. If relevant please specify any absolute requirements regarding medical investigations required, severity of disease, duration of exposure, latency time since exposure, any differences concerning recognition of cases caused by agents specifically mentioned in your national list and agents outside of the list.

Belgium. Ophthalmologic investigation, prick tests, RAST, occupational hygiene assessment.
Finland. Exclusion of other conditions and Exposure to a known allergen at work and typical anamnesis and clinical picture and Evidence of sensitisation to this allergen
Ireland. If the person suffered an eye condition due to accident at work they would be considered for benefit in the normal way.
Portugal. Recognition is based on: 1. Previous and current exposure to an agent that is recognised as a causative one for allergic conjunctivitis. 2. Clinical history of the patient 3. Positive examination by an expert in ophthalmology

104. Please specify below how you assess degree of disability due to allergic conjunctivitis in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Belgium. Only reimbursement of temporary treatment costs.
Finland. There is seldom any permanent physiological impairment. The degree of work disability is defined by the difference in the level of income before and after the diagnosis. There is seldom any work disability caused by conjunctivitis if the patient doesn't have any other allergic diseases at the same time.
France. Usually around 5-10%
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases. Reference values of the social security can't be given ,because socio-economic factors are also considered.
Portugal. Severity of symptoms and intensity of the lesions

IRRITANT EYE EFFECTS

105. Please list below all causative agents/exposures which are specifically mentioned in your national list of occupational diseases and are relevant for occupational irritant eye effects. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list (please state below if occupational irritant eye effects are not at all recognised in your national system).

Belgium. Sulphuric acid, Hydrochloric acid, Nitric acid, ionising radiation, halogenated aliphatic hydrocarbons, hydrogen sulphide
Denmark. Chromium and its compounds, Thallium.
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Irritant or related eye effects are specifically mentioned under the following items:
Ionising radiation (lens opacities)
IR radiation (lens opacities)
UV radiation (conjunctivitis and keratitis)
Arsenic and its compounds
Halogens and their inorganic compounds (chlorine, bromine, fluorine)
Phosgene
Inorganic bases and their anhydrides
Nitro and amino derivatives of hydrocarbons, amines
France. The condition is mentioned in about 15 tables of the national system which cover altogether about 30 agents
Germany. Benzoquinone.
Italy. It is a diseases outside of the list.
Luxembourg. Lead and its compounds
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". There is also a possibility to report cases caused by other agents

Portugal. There is no positive list of causative agents/exposures which are specifically mentioned in our national list of occupational diseases. The experts are free to recognise as causative agents the ones that are referred and commonly agreed as relevant in the available literature.
Spain. The item is not included in the national list, but could be dealt as an occupational accident.
United Kingdom. Prescribed disease C20 – dystrophy of the cornea (including ulceration of the corneal surface) of the eye caused by the use or handling of, or exposure to arsenic, tar, pitch, bitumen, mineral oil (including paraffin) soot or any compound or product or residue of any of these substances, except quinone of hydroquinone; or exposure to quinone or hydroquinone during their manufacture.

106. In addition to the agents/exposures specifically mentioned in your national list, does your national system include a possibility of recognising occupational irritant eye effects caused by other agents ?

No: United Kingdom, Ireland, France (always below 66,66% disability), Germany
Yes. Belgium, Denmark, Finland, The Netherlands, Portugal (see 105)

107. Please explain below the general recognition criteria which you use for occupational irritant conjunctivitis. If relevant please specify any absolute requirements regarding medical investigations required, severity of disease, duration of exposure, latency time since exposure, and any differences concerning recognition criteria of cases caused by agents specifically mentioned in your national list and agents outside of the list.

Belgium. Ophthalmologic investigation, industrial hygiene assessment
Finland. The diagnosis of an occupational disease is made at individual level, case to case.
Germany. Only damage to the cornea by benzoquinone is recognised.
Portugal. Recognition is based on: 1. Previous and current exposure to an agent that is recognised as a causative one for allergic conjunctivitis. 2. Clinical history of the patient 3. Positive examination by an expert in ophthalmology
United Kingdom. Not applicable. It could be considered under the accident provisions

108. Please specify below how you assess degree of disability due to irritant conjunctivitis in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Denmark. Very few cases. The degree of disability is minor (5-10%)
Finland. See 104.
France. Usually around 5-10%
Luxembourg. According to medical expertise.
Portugal. Severity of symptoms and intensity of the lesions
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". Reference values of the social security can't be given, because socio-economic factors are also considered.
United Kingdom. Not applicable.

109. Consider keratoconjunctivitis caused by UV light in your national system. Can this condition be recognised

	B	DK	D	E	F	IR L	I	L	NL*	A	P	FIN	UK
As an occupational disease								+	+				
As an accident at work				+		+				+			+
Both	+	+			+		**				+	+	
Not at all			+										

* There is no OD recognition scheme in NL, the answer refers to the notification scheme
** I : It could be an accident or a disease depending on the length of the exposure

110. Chemical eye irritants may cause several degrees of eye damage ranging from simple conjunctival irritation and tearing to severe corneal damage. Depending on the causative agent and its concentration these various types of eye irritation may differ a lot in duration of exposure, latency period between exposure and clinical manifestation. Some of these eye disorders may therefore be classified also as accidents at work. Please explain below how your national system defines which of the irritative eye effects are recognised as occupational diseases and which ones as accidents at work.

Austria. They are only recognised as accidents at work, not as occupational diseases.
Belgium. Accident at work: a rapid event, the cause of which or one cause of which is external to the injured and which has caused an injury. Occupational disease: A result of a prolonged exposure to a risk factor which occurs during the normal duties of the occupation.
Denmark. Very few cases. The assessment will be made case by case.
Finland. The compensation is run by the same insurance system and the respective legislation do not define the borderline very clearly, so it may not be clear which of these cases are coded as accidents and which as diseases.
France. Occupational disease: prolonged exposure. Accident at work: sudden, unusual exposure
Germany. Not applicable, since there is a clearly defined occupational disease (see above).
Ireland If a once off incident were involved over a short period (a few days), it would be regarded as an accident. If it were over a longer period the claim would be disallowed unless it came within the OD: Dystrophy of the cornea caused by use or handling or exposure to arsenic, tar, pitch, bitumen, mineral oil, soot or any compound product or residue of any of these substances except quinone or hydroquinone.
Italy. The difference between a disease and an accident depends on duration of exposure. In the occupational disease the duration of exposure must be long. In the accident it must be very short no more a duty
The Netherlands. All irritative effects, which are not noticeable immediately after the incident (some hours), are to be notified as occupational diseases. The irritative effect has to be of clinical importance or lead to impairment or incapacity.
Portugal. If symptoms start suddenly after acute exposure to an unusual high concentration of an irritative agent the situation will be considered as an accident at work. If the symptoms start progressively after a chronic exposure the situation will be considered an occupational disease.
Spain. The eye damages due to chemical splashes, burns, projections (for instance) will be recognised as work accidents. Our list of occupational diseases only includes corneal damages due to radiation energy exposure.
United Kingdom. Acute toxic incidents are classed as accidents. Chronic exposures resulting in disease are classed as prescribed (occupational) diseases.

CONTACT DERMATITIS

111. Please list below all causative agents/factors which are specifically mentioned in your national list of occupational diseases and are relevant for occupational contact dermatitis (contact eczema). Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list. If your national list makes a specific difference between allergic and irritant contact dermatitis as to the eligible causative agents/factors, please list the agents/factors under the appropriate title below.

111a. Contact dermatitis in general:
111b. Allergic contact dermatitis:
111c. Irritant contact dermatitis:
All three subquestions were similarly answered:

Austria. No specific agents are mentioned. Reference is made to item BK19 (General item of skin disease not specifying any agents) of the national list.
Belgium. A long list of scientifically recognised dermatitis provoking agents
Denmark. Chromium and nickel compounds are mentioned. In addition there is a general item for allergic skin disease (B2) and irritant skin disease (B3).
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Skin ailments are specifically mentioned under 29 of these.
France. About 60 agents or groups of agents are mentioned.
Germany. There is a general item for allergic and irritative skin diseases. No specific agents were mentioned in the questionnaire.
Ireland. Non infective dermatitis due to exposure to dust or liquid or vapour or any other heat external agent capable of irritating the skin.
Italy. See industrial list n. 42 and agricultural list n. 23. In the list is indicated skin disease in general and not contact dermatitis.
Luxembourg. Skin diseases which are severe or recurrent and have necessitated to quit all occupational activities which have been or may be in causal relation with occurrence, aggravation or recurrence of the disease
The Netherlands. No recognition scheme for ODs, reporting according to "Information notices"
Portugal. There are no specific causative agents mentioned in the national list. Cases caused by agents commonly agreed as relevant in the international literature can be recognised.
Spain. Although the disease is mentioned in our list, specifically, there is not a causative agents/factors list for this disease. The list is open without restrictions. The list includes all those skin affections caused, in the work environment, by solid substances, liquids, dust, vapours (which are not included in other sections of the list).
United Kingdom. 1. Prescribed disease C30 chrome dermatitis from exposure to chromic acid, chromates or bi-chromates. 2. Prescribed disease D5 Non-infective dermatitis of the external origin (excluding dermatitis due to ionising particles or electro-magnetic radiation other than radiant heat), due to exposure to dust, liquid or vapour or other external agent except chromic acid, chromates or bi-chromates, capable of irritating the skin (including friction or heat).

112. In addition to the agents specifically mentioned in your national list, does your national system include a possibility of recognising occupational contact dermatitis caused by other agents ?

Contact dermatitis in general, allergic contact dermatitis and irritant contact dermatitis:

No: France (disability always < 66,66%)
Yes: Austria, Belgium, Denmark, Finland, Italy, Luxembourg, The Netherlands, Portugal, Spain, United Kingdom

In Ireland and Germany the items as such are very broad.

113. Please explain below the general recognition criteria which you use for occupational contact dermatitis. If relevant please specify any absolute requirements regarding medical investigations required, severity of disease, duration of exposure, latency time since exposure, any differences concerning recognition of allergic and irritant cases and possible differences concerning recognition criteria of cases caused by agents specifically mentioned in your national list and agents outside of the list.

Austria. Severity of the disease and the workplace exposure are considered.
Belgium. Medical investigation, photographs, industrial hygiene assessment and if allergic, skin tests and RAST are used.
Denmark. A physician diagnosis is required. Occupational exposure to the causative agent must be more important than non-occupational exposure. All cases (almost) undergo an examination by a specialist of dermatology.
France. A recidive reaction confirmed by epicutaneous test.
Germany. The dermatitis must be either serious or recurrent. In addition, the disease must force the affected person to give up all activities which caused or could cause the disease or which could aggravate it or cause its recurrence.
Ireland. Non infective dermatitis due to exposure to dust or liquid or vapour or any other heat external agent capable of irritating the skin including friction or heat but excluding ionising particles or electro magnetic radiation other than radiant heat. The claimant is required to submit medical evidence to supply the claim that the condition is work related. If Disablement Benefit is claimed, level of loss is decided using the standard criteria.
Italy. Association between symptoms and work, onset of symptoms after entering the work-place, demonstration of sensitisation: patch test, prick test
Luxembourg. See 111.
The Netherlands. No recognition scheme for ODs, reporting according to "Information notices"
Portugal. There has to be 1. Evidence of exposure to an agent that recognised as causative of occupational contact dermatitis, 2. A positive clinical history of the patient, 3. Positive examination by an expert in Dermatology
Spain. The following are required: 1. Medical interview : a suspected occupational contact dermatitis, 2. A diagnosis of contact dermatitis, 3. Sensitisation to an occupational agent, 4. Relationship between occupational agent and contact dermatitis
United Kingdom. Long-term exposure to irritants. Long-term exposure to sensitising agents. Exposure to specific substances:

Chromic acid, alkali chromates and bichromates, or zinc chromates;

Anhydrous sodium carbonate (soda ash), mercury fulminate, quick lime and strong brine.

Skin tests may help to demonstrate sensitivity to specific substances.
Prescribed Disease D5 excludes dermatitis due to infecting organisms such as bacteria, fungi and animals parasites.

114. Consider a case with occupational allergic contact dermatitis. The worker is obliged to change job because it is not otherwise possible to eliminate exposure to the sensitising agent responsible for the allergic contact dermatitis. In the new job the worker is not exposed to the agent and the contact dermatitis is therefore completely cured. The worker however remains sensitised to the agent and risks to contract a new episode of dermatitis if exposed to the agent. In your national system, would you consider the worker as having some degree of permanent work disability ?

	B	DK	D	E	F	IRL	I	L	NL*	A	P	FIN	UK
Never									+		+		
Yes, if the agent is a commonly encountered allergen (e.g. nickel)	+	+					+			+			
Always			+					+					+
Other				+	+	+			+				

* There is no recognition scheme for ODs, the answer refers to the notification scheme

Other

E. A permanent disability for his/her present work could be defined.
F. The disability of first recognition will remain.
IRL. If a loss of faculty were assessed in respect of the first attack of dermatitis, she would get compensation under the Disablement Benefit Scheme. We would not regard the person as having some permanent degree of work disability.
FIN. For common allergens, a disability would be considered.

115. When assessing the disability due to occupational contact dermatitis, which of the following parameters are taken into account in your national system ? Choose all those which are used
116. Which of the parameters in question 115 is the main determinant of the degree of disability for dermatitis ?

	B	DK	D	E	F	IRL	I	L	NL*	A	P	FIN	UK
Severity of skin involvement	+	++		+		++	+	++		++	++	+	+
Area of skin involvement	+	+		+		+		+		+	+	+	+
Anatomical location of skin involvement	+	+		+			+			+	+	+	
Frequency of dermatitis episodes in the current job	+	+		+		++	+	+		++	+	+	+
Potential for later recurrent episodes	+			+		+				+		+	+
The worker's possibilities to avoid further exposure to the causative agent	+			+						+		+	
Other					+								

* There is no recognition scheme for ODs, the answer refers to the notification scheme

Other

D. There are no concrete definitions.

E. All these parameters could be used for diagnosis establishment. But there is no standardised guide for diagnosis. In most cases, that depends on physician's criteria.

F. A complex system taking into account severity of atrophy, alopecia, dyschromia and ulceration as well as anatomical location and functional consequences of the dermatitis is used.

NL. All these parameters may be taken into account, depending on the individual case. None are obligatory.

117. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Denmark. 10%: slight chronic eczema and frequent eruptions. 20 %: severe chronic eczema with eruptions 3-4 times a year.
France. A complex system is used, taking into account severity of atrophy, alopecia, dyschromia and ulceration as well as anatomical location and functional consequences of the dermatitis.
Ireland. As with other cases, the level of loss of faculty depends on the severity of the disease. To be considered incapable of work because of the incapacity a 20% loss of faculty must apply. In the case of less than 20% assessments, a gratuity or pension would be payable. The level of loss of faculty is assessed following clinical examination by one of the Department's doctors having regard to the person's health with that of a person of the same age and sex in normal health.
Italy. It depends on anatomical location, associated infections, interested functionality.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". Reference values of the social security can't be given, because socio-economic factors are also considered.
Portugal. The negative impact of the disease on the patient's activities is assessed.
Spain. There is not a standardised guide to quantify the degree of disability degree. Generally, the qualitative evaluation is set following the physician's criteria.

United Kingdom. Threshold for benefit is 14%. Each case is assessed on its merits, it is not possible to give a 'typical profile.

118. Skin irritants may cause several degrees of skin damage ranging from simple erythema to third degree chemical burns. Depending on the causative agent and its concentration these various types of skin irritation may differ a lot in duration of exposure and latency period between exposure and clinical manifestation. Some of these skin manifestations may therefore be classified also as accidents at work. Please explain below how your national system defines which of the irritative skin effects are recognised as occupational diseases and which ones as accidents at work.

Austria. Accidents at work
Belgium. Accident at work: a sudden event, the cause of which or one cause of which is external to the injured and which has caused an injury. Occupational disease: A result of a prolonged exposure to a risk factor which occurs during the normal duties of the occupation.
Denmark. These types of irritative skin effects will usually be recognised as occupational diseases. However, if the skin damage occurs as a result of a sudden event, for instance a chemical burn on a person's hand as a consequence of an external factor, then the skin damage will be recognised as an accident at work.
Finland. The compensation is run by the same insurance system and the respective legislation do not define the borderline very clearly, so it may not be clear which of these cases are coded as accidents and which as diseases.
France. Occupational disease: prolonged exposure. Accident at work: sudden, unusual exposure
Germany. If the skin damage is accidental, it is generally treated as an accident.
Ireland. If a once off incident were involved at work, it would be regarded as an accident and accordingly allowed. If it developed over a period of more than a few days, it would be examined to dee if it came within the scope of our OD's. However, the list of substances as indicated earlier under our scheme, is very broad for contracting dermatitis.
Italy. Accident when the duration of exposure was short no more a duty
Luxembourg. Accident: a sudden event with duration no longer than 8 hours. Otherwise OD.
The Netherlands. All irritative effects, which are not noticeable immediately after the incident (some hours), are to be notified as occupational diseases. The irritative effect has to be of clinical importance or lead to impairment or incapacity.
Portugal. If symptoms start suddenly after acute exposure to an unusual high concentration of an irritative agent the situation will be considered as an accident at work. If the symptoms start progressively after a chronic exposure the situation will be considered an occupational disease.
Spain. In general, those acute skin damages which are due to chemical splashes, burns, projections (for instance) will be recognised as work accidents.
United Kingdom. Acute toxic incidents are classed as accidents. Chronic exposures resulting in disease are classed as prescribed (occupational) diseases

INFECTIONS

119. Please list below all the infectious diseases (including parasitic diseases) which are specifically mentioned in your national list of occupational diseases. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list.

See Part 7.

120. In addition to the infectious diseases specifically mentioned in the national list, can other infectious diseases be recognised in your national system ?

No: Germany, Ireland, Italy (see 119), United Kingdom
Yes: Belgium, Denmark, Finland, France, Luxembourg, The Netherlands, Portugal, Spain

No answer: Austria

121. Can infectious diseases be recognised also as occupational accidents in your national system ?

No: Austria, Germany, The Netherlands, Portugal
Yes: Belgium, Denmark, Finland, France, Ireland, Italy (see 119), Luxembourg, Spain, United Kingdom

122. If YES in 121, can any the infectious diseases mentioned in the list of occupational diseases be also recognised as accidents?

No: Spain
Yes: Belgium, Denmark, Finland, France, Ireland, Luxembourg, United Kingdom

123. If infectious diseases can be recognised both as occupational diseases and occupational accidents in your national system, please specify below how the borderline between those recognised as diseases and those recognised as accidents, has been defined

Belgium. Recognition as an OD if 1. The juridical criteria of accident at work are not met or if 2. The normal incubation period of the disease is passed in comparison to the date of the accident.
Denmark. If an infectious disease is recognised as an accident, it must have been caused by an external event which has happened suddenly and without the injured person's intent. For example a stab or prick.
Finland. If the onset is related to a clear accident (e.g. needle stick), the later consequences (the infectious disease, e.g. hepatitis) will probably be recognised as the consequence of the accident.
France. If it is possible to determine a date of an accidental transmission, it will be considered an accident at work.
Ireland. If the person contracted the disease due to an accident at work, it would be accepted. If the disease were due to a short acute contact with the substance over a short period, usually a few days at most, it would also be accepted as an accident. If contact was over a longer period, it would have to be examined to see if it came within the scope of our OD's.
Luxembourg. Accident if due to an injury.
Spain. Accident: those infections which are not specifically included in the list of OD (e.g. AIDS)
United Kingdom. In most cases the disease would be classed as a prescribed disease. It would depend on the circumstances of the individual case as to whether it could be considered as an accident.

NOISE-INDUCED HEARING LOSS

124. When assessing the permanent disability due to hearing loss, which of the following parameters are taken into account in your national system ? Choose all those which are used
125. Which of the parameters in question 124 is the main determinant of the degree of disability for hearing loss in your country ?

	B	DK	D	E	F	IRL	I	L	NL*	A	P	FIN	UK
Pure-tune audiogram, air conduction, hearing threshold in the better ear		+		++		+		++					+
Pure-tune audiogram, air conduction, hearing threshold in the worse ear		+		++	++	+						+	+
Pure-tune audiogram, bone conduction, hearing threshold in the better ear	++	+		+	+		++				++	++	+
Pure-tune audiogram, bone conduction, hearing threshold in the worse ear		+		+			+				+		+
Speech audiogram, hearing threshold in the better ear		+		+				++					
Speech audiogram, hearing threshold in the worse ear		+		+									
Symptoms (e.g. tinnitus)		+	+					+			+		+
Other		+	++						+	+			+

* There is no recognition scheme for ODs, the answer refers to the notification scheme

Other

DK. The system doesn't make use of pure-tune audiometry thresholds as a predominant audiological measure, but is based on speech perception. Combination of individual self-assessment of semantic speech perception and objective audiological measurements are the most important.

D. Speech audiogram for both ears. Pure-tune audiogram when there are problemd with the speech audiogram.

NL. All these parameters may be taken into account, depending on the individual case. None are obligatory.

A. Speech audiogram Hearing loss + discrimination loss in keeping with the tables compiled in accordance with Boenninghaus and Röser. Percentage hearing loss is the most important.

UK. The reference to permanent disability is not relevant to UK occupational deafness. For a claim for noise induced hearing loss to succeed the claimant must meet (1) employment criteria – earned employment of at least 10 years in a prescribed occupation with claim made within 5 years of leaving the occupation (2) audiometric criteria for occupational deafness must be met i.e. average sensorineural hearing loss 50 dB over 1, 2 & 3 kHz in each ear and in at least one ear due to occupational noise

Assessment where these criteria are met uses a scale relating average impairment over 1, 2 & 3 kHz to percentage disablement. The threshold of disablement is at 30 dBs average over 1, 2 & 3 kHz and 100 per cent is at 106 or more average dB over 1, 2 & 3 kHz. 50 dB loss is associated with 20 per cent assessment. Addition or reduction of assessment on the basis of evidence based medical judgement may be made e.g. for tinnitus.

126. Which frequencies (kHz) in the audiogram are used in the calculation of the above main parameter:

Belgium:	1,2 and 3 kHz
Denmark:	-
Finland:	0.5, 1, 2 kHz
France:	0.5, 1, 2, 4 kHz
Germany:	1,2 and 3 kHz
Ireland:	1, 2 and 3 kHz
Italy:	0.5, 1, 2, 3, 4, kHz
Portugal:	0.5, 1, 2, 4, kHz
Spain:	from 0.125 to 8 kHz
United Kingdom:	1, 2 and 3 kHz

127. What is the "threshold" value for the above main parameter to result in a degree of disability of 10 % and 20 %. If it is not possible to point out a main parameter and its threshold values, please describe the typical profile of relevant parameter values to result in a degree of disability of 10 % and 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Austria. Disability is determined in accordance with Feldmann's table and percentage hearing loss using Röser's tone audiogram
Denmark. A complex system is used.
Finland. For 10 % permanent physiological impairment: 20-29 dB. For 20 % permanent physiological impairment: 40-49 dB.
France. A weighted average of the hearing loss in both ears (2x0.5kHz + 4x1kHz + 3x2kHz + 1x4kHz)/10 is calculated. A hearing loss of 35 dB (i.e. the recognition threshold) in both ears corresponds to 8-18%, 36dB in both ears corresponds to 18%. A disability of 24% corresponds to a hearing loss of 35-45 dB in on ear and 45-55dB in the other ear.
Germany. 10%: hearing loss of 20 %. 20%: hearing loss of 40 %
Hearing loss is determined from speech audiogram in a special way, described in
"Empfehlungen des HVBG für die Begutachtung der beruflichen Lärmschwerhörigkeit"
ISBN 3-88383-393-2, Pages 21 - 23
Ireland. Minimum hearing loss of 50 decibels in each ear. Minimum award for occupational hearing loss is 20%.
Italy.
It normal an threshold of audibility not above 25 dB for any frequencies.

Frequencies(Hz)	lost right ear (dB)	lost right ear
500	10	20
1000	20	35
2000	35	40
3000	40	50
4000	60	60
	disability 10%	disability 20%

The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". Reference values of the social security can't be given, because socio-economic factors are also considered. In practice it doesn't happen that workers are entitled to a disability benefit because of hearing loss. In national social security statistics the diagnosis of hearing loss is nonprevalent.

Portugal. The minimum degree of disability according to our national list is 15%. In order to get this degree of disability a patient must a have a hearing loss of 35 dB calculated in the audiogram and based on the frequencies listed above (please see answer 126).

United Kingdom.

10 per cent is below the threshold of compensation. Cases with this level of impairment do not meet the diagnosis occupational deafness.

20 per cent equates to 50 dB average over 1, 2 & 3 kHz and meets the definition of occupational deafness and is the threshold of disablement. No awards are made for lower levels of disablement.

Case 4. Consider a 56-years old man, who has a noise-induced hearing loss fulfilling the recognition criteria used in your country. His pure-tune audiogram shows the following hearing thresholds (reduction of hearing capacity, air conduction). No previous measurements are available:

Frequency (kHz)	Threshold, right ear (dB)	Threshold, left ear (dB)
0.5	25	35
1	35	50
2	40	50
3	45	55
4	50	55
6	50	60
8	50	60

128. What would be the current degree of disability of this case 4 in your national OD system ?

Austria:	20%)
Belgium:	0%
Denmark:	not possible to answer as audiometry is not the main determinant
Germany:	20%
Finland:	20%
France:	24%
Ireland:	0%
Italy:	24% if bone conduction equal to air conduction
Luxembourg:	15%
The Netherlands:	not possible to answer, data on earnings needed
Portugal:	16%
Spain:	no answer
United Kingdom:	0%

129. Comments of case 4. If you were not able to answer question 128, please explain why.

Denmark. The main parameters are missing (see 124/125). Hearing threshold elevated in the low and middle frequencies + asymmetric hearing loss. This indicates that there might be other factors than noise-induced hearing loss.

Germany. Pure-tune audiogram is not primarily used

Ireland. 52dB loss in right ear. 40 dB loss in left ear – less than 50, therefore fails on hearing loss criterion.

Italy. It doesn't look like typical noise induced hearing loss.

United Kingdom. Criteria not met for occupational deafness as the average loss in the right ear is below 50dB. No assessment no award.

PARALYSIS OF NERVES

130. Which of the following nerve paralyses are specifically mentioned in your national list of occupational diseases

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Only paralysis of nerves in general	+		+						+	+		
Not at all mentioned						+	+				+	
Carpal tunnel syndrome		+		+	+			+				+
Tarsal tunnel syndrome				+				+				
Gyon's cavity syndrome				+	+							
Ulnar nerve groove syndrome				+	+	+		+				
Compression of the external popliteal nerve				+	+							
Other												

No recognition scheme in NL, reporting according to "Information notices"

131. If paralysis of nerves is not mentioned in your national list, can such conditions, however be recognised as an OD.

No: Ireland
Yes: Finland, Italy

132. Concerning carpal tunnel syndrome, which risk factors are considered relevant for the recognition in your national system ? Choose all which are considered relevant

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Direct local pressure		+		+	+		+	+		+		
Indirect local pressure				+	+					+		
Vibration/use of vibrating tools	+	+		+					+			+
Work involving monotonous movements	+	+		+	+		+	+		+		
Work involving extreme postures of the wrist	+	+		+	+		+			+		
Other												
Not at all			+			+						
Only open system							+				+	

No recognition scheme in NL, reporting according to "Information notices"

133. Please specify below how you assess degree of disability due to carpal tunnel syndrome in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The answers were very heterogeneous as regards the level of details presented. They are not reported.

BURSITIS

134. Which of the following forms of bursitis are specifically mentioned in your national list of occupational diseases ? Choose all which are mentioned

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Our national list mentions only bursitis in general	+	+						+		+		
Bursitis is not at all mentioned in the national list of OD							+					
Bursitis of the elbow				+	+	+		+	+		+*	+
Bursitis of the knee				+	+	+		+	+		+*	+
Other			+	+							+	+

* these are mainly considered as accidents at work

No recognition scheme in NL, reporting according to "Information notices"
Other

FIN. Bursitis (inflammation of the patella or elbow due to repeated or unusual pressure) is mentioned only in the Statute of Certain Injuries Compensable as Occupational Accidents (852/48).
UK. Bursitis etc of the hand.

135. If bursitis is not mentioned in your national list, can such conditions, however be recognised as an OD.

No: -
Yes: Italy

136. Do you recognise acute bursitis (temporary sick leave) as an OD ?

No: Germany, Ireland, United Kingdom
Yes: Belgium, Denmark, Finland (see 134), France, Italy, Luxembourg, Portugal, Spain

137. Do you recognise chronic bursitis (permanent disability) as an OD ?

No: -
Yes: Belgium, Denmark, Germany Finland (see 134), France, Italy, Luxembourg (depends on exposure), Portugal, Spain, United Kingdom

138. Please specify below how you assess degree of disability due to bursitis in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The answers were very heterogeneous as regards the level of details presented. They are not reported.

TENDINITIS ETC.

139. Which of the following conditions are mentioned in your national list of OD ? Choose all which are mentioned

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Only tendinitis in general	+ *			+				+		+	+	
Not at all			+				+					
tendinitis of the wrist		+			+	+		+				
Tendinitis of the hand		+			+	+		+				+
Tendinitis of the forearm		+				+		+				+
Tendinitis of the shoulder		+			+			+				
Tendinitis of the ankle					+			+				
Tendinitis of the foot					+			+				
Tendinitis of the knee								+				
Other location												

* actors only

No recognition scheme in NL, reporting according to "Information notices"

140. If the above specific sites of tendinitis etc. are not mentioned in your national list, can they, however be recognised as an OD.

No: Ireland, United Kingdom
Yes: Austria, Belgium, Finland, France (if > 66,66% of disability), Italy, Portugal

141. Which of the following risk factors are considered relevant for the recognition of tendinitis/tenosynovitis/peritendinitis in your national system ? Choose all which are considered relevant

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Direct local pressure				+	+					+		
Indirect local pressure				+	+					+		
Vibration/use of vibrating tools	+			+	+				+	+		
Work involving vigorous movements	+	+		+	+		+					
Work involving monotonous movements	+	+		+	+		+	+		+		+
Work involving extreme postures	+				+		+			+		
Other						+					+	

No recognition scheme in NL, reporting according to "Information notices"
Other

FIN. Performing repetitive, monotonous or strained movements.
IRL. Manual labour or frequent or repeated movements of the hand or wrist

142. Do you recognise acute tendinitis/tenosynovitis/peritendinitis as an OD in your national system ?

No: Austria, Germany, Portugal
Yes: Belgium, Denmark, Finland, France, Ireland, Italy, Spain, United Kingdom

143. Do you recognise chronic tendinitis/tenosynovitis/peritendinitis as an OD in your national system ?

No: Germany,
Yes: Austria, Belgium, Denmark, Finland, France, Ireland, Italy, Portugal, Spain, United Kingdom

144. Please specify below how you assess degree of disability due to tendinitis etc. in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:
The answers were very heterogeneous as regards the level of details presented. They are not reported.

DISEASES OF THE MUSCULAR OR TENDONOUS INSERTIONS

145. Which of the following conditions are mentioned in your national list of OD ? Choose all which are mentioned

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Only diseases of the muscular or tendonous insertions in general	+ *		+	+				+				
No diseases of the muscular or tendonous insertions are mentioned in our national list						+	+					+
Epicondylitis in general					+			+		+	+	
Lateral epicondylitis		+						+				
Medial epicondylitis								+				
Other												

* actors only

No recognition scheme in NL, reporting according to "Information notices"

146. If the above specific sites of diseases of muscular or tendonous insertions are not mentioned in your national list, can they, however be recognised as an OD.

No: France (disability always < 66,66%), United Kingdom
Yes: Austria, Belgium, Finland, Ireland, Italy, Portugal

OTHER MUSCULOSCELETAL DISORDERS

147. Is low back pain mentioned in your national list of OD ?

No: Austria, Belgium, Finland*, Ireland, Italy, Luxembourg, Portugal, Spain, United Kingdom
Yes: Denmark, France, Germany (only special cases)

* e.g. muscular pain recognised only as an accidental injury

148. If low back pain is not mentioned in your national list of OD, can such cases, however, be recognised as an OD in your country ?

No: Austria, Ireland, Italy, Spain, United Kingdom
Yes: Belgium, Portugal

149. Is sciatic syndrome mentioned in your national list of OD ?

No: Austria, Belgium, Germany, Finland*, Ireland, Italy, Luxembourg, Portugal, United Kingdom
Yes: Denmark, France, Spain

* only in relation to an accidental injury

150. If sciatic syndrome is not mentioned in your national list of OD, can such cases, however, be recognised as an OD in your country ?

No: Austria, Germany, Ireland, Italy, United Kingdom
Yes: Belgium, Luxembourg, Portugal

151. Is neck pain mentioned in your national list of OD ?

No: Austria, Belgium, Finland*, France, Ireland, Italy, Luxembourg, Portugal, Spain, United Kingdom
Yes: Denmark, Germany (only special cases)

* e.g. muscular pain recognised only as an accident

152. If neck pain is not mentioned in your national list of OD, can such cases, however, be recognised as an OD in your country ?

No: Austria, Ireland, Italy, Spain, United Kingdom
Yes: Belgium, France, Luxembourg, Portugal

153. Are cervical disc disorders mentioned in your national list of OD ?

No: Austria, Belgium, Finland*, France, Germany, Ireland, Italy, Luxembourg, Portugal, Spain, United Kingdom
Yes: Denmark

* only in relation to an accident at work

154. If cervical disc disorders are not mentioned in your national list of OD, can such cases, however, be recognised as an OD in your country ?

No: Austria, Ireland, Italy, Spain, United Kingdom
Yes: Belgium, France, Luxembourg, Portugal

155. Are meniscal disorders of the knee mentioned in your national list of OD ?

No: Belgium, Finland, Italy, United Kingdom
Yes: Austria, Denmark, France, Germany, Ireland, Luxembourg, Portugal, Spain

156. If meniscal disorders are not mentioned in your national list of OD, can such cases, however, be recognised as an OD in your country ?

No: United Kingdom
Yes: Belgium, Finland, Italy

HAND-ARM VIBRATION EFFECTS

157. Which of the following conditions are specifically mentioned in your national list of OD regarding vibration effects affecting the hand-arm region ? Choose all which are mentioned

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Our national list only mentions hand-arm vibration syndrome in general								+		+		
Vibration effects on the hand-arm region are not at all mentioned in the list												
Vascular effects		+		+	+	+	+	+		+	+	+
Neurological effects		+		+	+			+		+	+	
Osteoarticular disorders		+		+	+		+	+		+		
Other	+	+	+			+			+			

No recognition scheme in NL, reporting according to "Information notices"
Other

B. 1.605.01 Osteoarticular diseases provoked by mechanical vibrations (covers both upper limbs and the lumbar column)
DK. Vibration-induced white finger, neuropathy, carpal tunnel syndrome.
D. 1. Diseases caused by vibration when working with pneumatic tools or tools or machines with a similar effect. 2. Circulatory problems in the hands caused by vibration
IRL. Vibration induced white finger.
A. Reference to item BK20 of the national list

158. In your data system, which of the following hand-arm vibration effects are you able to identify as separate entities. Choose all which you can identify in your system

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Vascular effects	+				+	+	+	+		+		+
Neurological effects	+				+			+		+		
Osteoarticular disorders	+				+		+	+		+		
Other		+	+	+							+	

No recognition scheme in NL, reporting according to "Information notices"
Other

DK. Not able to identify these effects separately
D. 1. Diseases caused by vibration when working with pneumatic tools or tools or machines with a similar effect. 2. Circulatory problems in the hands caused by vibration
E. None can be identified separately
I. Not able to identify these effects separately
FIN. Only hand-arm vibration in general and sometimes polyneuropathy

159. Please specify below how you assess degree of disability due to hand-arm vibration effects in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Austria. According to functional loss
Denmark. Mild attacks 5%, moderate 10%, severe 15%.
France. For osteoarticular diseases 5-30% according to function and pain. 10% corresponds to approximately a situation where the flexion and the extension angle of the thumb are around 30 degrees. 20% to a more severe flexion-extension impairment and an impairment in the pronation-supination movements. For arthrosis of the wrist the disability is 15-25%. For angioneurotic diseases 5-10% corresponds light cases and 20-30% to severe cases.
Germany. There are no concrete definitions.
Ireland. Following clinical examination by one of the Department's doctors and is decided by comparing the claimant with a person of the same age and sex in normal health.
Italy. According to the Stockholm workshop 1996. Stage 1-2 10%, stage 2-3 20%.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases". Reference values of the social security can't be given, because socio-economic factors are also considered.
Portugal. The degree of disability is assessed taking into consideration pain, neurological disturbances (sensitive damage) and functional status (mobility deficit and degree of angular limitation).
Spain. There is not a standardised guide to quantify the degree of disability degree. Generally, the qualitative evaluation is set following the physician's criteria.
United Kingdom. The prescription for Prescribed disease A11 specifies: Episodic blanching, occurring throughout the year, affecting the middle or proximal phalanges or in the case of a thumb, the proximal phalanx of: 1. In the case of a person with five fingers (including thumb) on one hand, any three of those fingers, or 2. In the case of a person with only 4 such fingers. Only 2 of those fingers, or 3. In the case of a person with less than 4 such fingers, any one of those fingers, or as the case may be, the one remaining finger (vibration white finger). However each case assessed on its merits, therefore not possible to give this information

WHOLE-BODY VIBRATION EFFECTS

160. Are diseases caused by whole-body vibration mentioned in your national list of OD ?

No: Belgium, Denmark, Finland, Ireland, Italy, Luxembourg, Portugal, United Kingdom
Yes: Austria, France, Germany, The Netherlands (reporting scheme), Spain

161. If YES in 160, please specify which diseases are considered eligible for recognition as a result of whole-body vibration

Austria. Reference to item BK20 of the national list.
Germany. Diseases involving lumbar herniated discs.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases.
Spain. It is not possible to separate hand-arm vibration and whole body vibration effects.

DISEASES CAUSED BY HIGH OR LOW PRESSURE

162. Are diseases caused by pressure exceeding atmospheric pressure mentioned in your national list of OD ?

No: -
Yes: Austria, Belgium, Denmark, Finland, France, Germany, Italy, Ireland, Luxembourg, The Netherlands (reporting scheme), Portugal, Spain, United Kingdom

163. If YES in 162, please specify which diseases are considered eligible for recognition as a result of pressure exceeding atmospheric pressure

Austria. Osteo-arthropathy in the shoulder and hip regions
Belgium. Barotraumatic otitis
Denmark. The list mentions Diseases due to work in compressed air.
Finland. Direct effects: maxillary haemorrhages and tympaneal ruptures. Indirect effects: diver's disease and as long term effects aseptic bone necrosis of the big joints
France. Osteonecrosis, vertigo, otitis media, hearing loss.
Germany. The list states "diseases caused by working in compressed air". This means that in principle all diseases attributable to this specific exposure are covered.
Ireland. Dysbarism including decompression sickness, barotrauma and osteonecrosis subject to compressed or rarefied air or other respirable gases or gaseous mixtures.
Italy. The list specifies the risk, but not the diseases.
Luxembourg. Diseases due to work in compressed air.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Portugal. Osteonecrosis (shoulder, knee), otitis media (sub acute and chronic) and hearing loss.
Spain. Diseases related to sub-aquatic work
United Kingdom. Prescribed disease A3 – Dysbarism, including decompression sickness, barotrauma and osteonecrosis due to subjection to compressed or rarefied air or other respirable gases or gaseous mixtures.

164. Are diseases caused by pressure below atmospheric pressure mentioned in your national list of OD ?

No: Austria, Denmark, Finland, Germany, Ireland, Italy, Luxembourg, Portugal
Yes: Belgium, France, The Netherlands (reporting scheme), Spain, United Kingdom

165. If YES in 164, please specify which diseases are considered eligible for recognition as a result of pressure below atmospheric pressure

Belgium. Otitis, osteonecrosis.
France. Otitis media (subacute or chronic), lesions of the internal ear,
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Spain. Diseases related to pressure system failure during high altitude flights.
United Kingdom. Prescribed disease A3 – Dysbarism, including decompression sickness, barotrauma and osteonecrosis due to subjection to compressed or rarefied air or other respirable gases or gaseous mixtures.

NEUROLOGICAL DISORDERS DUE TO EXPOSURE TO ORGANIC SOLVENTS OR OTHER NEUROTOXIC AGENTS

166. Is polyneuropathy specifically mentioned in your national list of occupational diseases

No: Belgium, Ireland, Italy, Spain, United Kingdom
Yes: Austria, Denmark, Finland, France, Germany, Luxembourg, The Netherlands (reporting scheme), Portugal

167. If YES in 166, please specify below which are the causative agents/exposures specifically mentioned for polyneuropathy in your national list of occupational diseases.

Austria. Reference is made to BK52 (polyneuropathy and encephalopathy due to organic solvents or their mixtures) of the national list.
Denmark. Hexane, methylbutylketone, phosphorus, lead
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Polyneuropathy is specifically mentioned under the following items: Vibration (upper extremity), Arsenic and its compounds, Mercury and its compounds, Lead and its compounds, Manganese and its compounds (neurological effects in general), Cyano compounds (neurological effects in general), Carbon disulphide, Aliphatic, aromatic and alicyclic hydrocarbons, Halogenated derivatives of hydrocarbons, Aldehydes, ketones, alcohols, ethers and esters (neurological effects in general).
France. A variety of chemicals and groups of chemicals are mentioned for various neurological conditions.
Germany. Organic solvents and their mixtures.
Italy. There is no list of causative agents for polyneuropathy, but such disorders may be included under many agents mentioned in the list.
Luxembourg. Organic solvents and their mixtures.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Portugal. Lead, arsenic, carbon disulphide and hexane
Spain. Polyneuropathy is not specifically mentioned, but may be included under many of the chemicals mentioned in the list.
United Kingdom. As peripheral neuropathy - n-hexane or methyl n-butyl ketone.

168. Are cases of polyneuropathy recognised also under more general items of your national list (e.g. poisonings, neurological intoxication in general)

No: Austria, Belgium, Italy, The Netherlands
Yes: Denmark, Germany, Ireland, Finland, France, Luxembourg, Portugal, Spain, United Kingdom

169. If YES in 168, can you identify cases of polyneuropathy separately under such items of your national list

No: Denmark, Finland, Spain, United Kingdom
Yes: France, Germany, Luxembourg, Portugal

170. If NO in 169, please specify below the causative agents/exposures for which you can't separate polyneuropathy from other toxic entities in your national registry

Belgium. Lead, Arsenic, Trichlorethylene, Methyl-n-butylketone, n-Hexane, carbontetrachloride
Denmark. Organic solvents in general.
Finland. If there is a more severe condition caused by the same agent at the same time, polyneuropathy is usually not coded as a separate entity
Spain. Generally, it is only possible to identify the agent but not the disease. For instance, the system registers "disease caused by lead exposure" but it may be difficult to know whether it concerns a case of anaemia or neuropathy.
United Kingdom. Phosphorus or inorganic compound of or poisoning due to anticholinesterase or pseudo anticholinesterase action of organic P compounds – carbon disulphide – methyl bromide – acrylamide monomer.

171. Please specify below how you assess degree of disability due to polyneuropathy in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Austria. Neurological examinations, Workplace assessment, Occupational anamnesis and follow-up are conducted.
Denmark. Very few cases. No specifications.
Germany. There are no definitions.
Ireland. Following clinical examination by one of the Department's doctors and is decided by comparing the claimant with a person of the same age and sex in normal health.
Italy. A neurological examination and neurological tests are performed.
Portugal. Pain, neurological disturbances and functional status are considered.
Spain. There is not a standardised guide to quantify the degree of disability. Generally, the qualitative evaluation is set following the physician's criteria.
United Kingdom. Legislation sets out the method of assessment of disablement – which is in terms of loss of faculty. (Approximately WHO impairment). Assessment is without reference to special circumstances other than age, sex and physical and mental condition. Because the scheme covers a range of disablements to preserve equity and consistency it contains a list of Statutory Scheduled Assessments which are used as benchmarks for all disablements. Assessment is expressed as a percentage. The Secretary of State is the decision maker. Acts on advice from doctors who reach assessment by application of clinical judgement to evidence of the case and contemporary medical understanding. Reasons for assessment given to Secretary of State.

172. Is chronic toxic encephalopathy (CTE) specifically mentioned in your national list of occupational diseases

No: Belgium, France, Ireland, Italy, Portugal, Spain, United Kingdom
Yes: Austria, Denmark, Finland, Germany, Luxembourg, The Netherlands (reporting scheme)

173. If YES in 172, please specify below which are the causative agents/exposures specifically mentioned for CTE in your national list of occupational diseases.

Austria. Reference is made to BK52 (polyneuropathy and encephalopathy due to organic solvents or their mixtures) of the national list.
Denmark. Mercury and compounds, Hydrocarbons and hydrocarbon derivatives, carbon monoxide, hydrocyanic acid, cyanic compounds, cyanates
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Central nervous effects or CTE is specifically mentioned under the following items: Mercury and its compounds, Phosphorus and its compounds, Lead and its compounds, Manganese and its compounds (neurological effects in general), Cyano compounds (neurological effects in general), Carbon disulphide, Aliphatic, aromatic and alicyclic hydrocarbons, Halogenated derivatives of hydrocarbons, Nitroglycerol and nitroglycol, Aldehydes, ketones, alcohols, ethers and esters (neurological effects in general).
France. A variety of chemicals and groups of chemicals are mentioned for various neurological conditions.
Germany. Organic solvents and their mixtures.
Luxembourg. Organic solvents and their mixtures.
The Netherlands. Organic solvents (reporting scheme)
Spain. Encelopathy is not specifically mentioned, but may be included under many of the chemicals mentioned in the list.

174. Are cases of CTE recognised also under more general items of your national list (e.g. poisonings, neurological intoxication in general)

No: Austria, Belgium, Denmark, Finland, France, Italy, Portugal
Yes: Germany, Ireland, Luxembourg, The Netherlands, Spain, United Kingdom

175. If YES in 174, can you identify cases of CTE separately under such items of your national list

No: Ireland, The Netherlands, Spain, United Kingdom
Yes: Germany, Luxembourg

176. If NO in 175, please specify below the causative agents/exposures for which you can't separate CTE from other toxic entities in your national registry

Belgium. All (toluene, xylene, acrylamide, carbon sulphide, methylbromide, mercury, tetraethyl-lead
Spain. Generally, it is only possible to identify the agent but not the disease. For instance, the system registers "disease caused by lead exposure".
United Kingdom. Manganese – acrylamide monomer – mercury – methyl bromide – Gonomia kamassi

177. Please specify below how you assess degree of disability due to CTE in your national system. List all the parameters used, indicate which one is the main determinant of the degree of disability and which are the values of that main parameter or a typical parameter profile to result in a degree of disability of 10 % and of 20 %. If either of these percentages is an important cut-off point in your national system, please indicate that also and give information concerning the parameter values around this cut-off point:

Austria. see 171.
Denmark. light 20%, light-medium 35%, medium 50%, severe 75%
Germany. see 171.
Ireland. see 171.
Italy. see 171
Spain. see 171
United Kingdom. see 171

NEPHROTOXIC EFFECTS

Note that malignant diseases are addressed in questions 97-100. Do NOT consider them here.

178. Please specify below the causative agents/exposures which are mentioned for nephrotoxic effects (e.g. toxic nephropathy) in your national list of OD

Austria. Reference is made to the following items of the national list: BK1 (Lead and compounds), BK2 (Phosphorus and compounds), BK3 (Mercury and compounds), BK4 (Arsenic and compounds), BK6 (Cadmium and compounds), BK8 (Chromium and compounds), BK9 (Benzene and homologues), BK10 (Nitro- and aminoderivatives of benzene etc.), BK13 Carbon disulphide), BK18 (Cancer etc. caused by aromatic amines) , BK47 (Butyl-, methyl- and isopropylalcohol), BK48 (Phenols etc.), BK51 (Halogenated alkyl-, akryl- or alkylaryloxides)
Belgium. -
Denmark. Mercury, Lead, Organic solvents.
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Nephrotoxic effects are specifically mentioned under the following items: Mercury and its compounds, Cadmium and its compounds, Lead and its compounds, Phenols and its homologues and their halogen and nitro derivatives
France. Nephrotoxic and related effects are mentioned in 14 of the national tables. These include about 50 chemical or biological specific agents.
Germany. These diseases are not included in the list.
Ireland. Not specifically mentioned in the list.
Italy. There is no list of causative agents for nephrotoxic effects, but such disorders may be included under many agents mentioned in the list.
Luxembourg. Chemicals.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Portugal. Lead, mercury, cadmium, arseniad hydrogen and carbon tetrachlorid.
Spain. Nephrotoxic effects are not specifically mentioned, but may be included under many of the chemicals mentioned in the list (for instance, mercury cadmium and other metal exposure).
United Kingdom. No such category.

179. In addition to the agents in your national list, does your national system include a possibility of recognising nephrotoxic effects caused by other causative agents ?

No: Ireland, United Kingdom
Yes: Austria, Belgium, Denmark, Finland, France, Italy, The Netherlands, Portugal, Spain

No answer: Germany, Luxembourg

180. Are cases of nephrotoxic effects recognised also under more general items of your national list (e.g. poisonings in general)

No: Austria, Belgium, Denmark, Ireland, Italy, Portugal
Yes: Finland, France, Germany, Luxembourg, Spain, United Kingdom

181. If YES in 180, can you identify cases of nephrotoxic effects separately under such items of your national list

No: Finland, Italy, The Netherlands, Spain, United Kingdom
Yes: France, Germany, Luxembourg

182. If NO in 181, please specify below the causative agents/exposures for which you can't separate nephrotoxic effects from other toxic entities in your national registry

Finland. If a nephrotoxic effect is part of a more general poisoning, it can probably not be identified as a separate entity.
The Netherlands. See question 178.
Spain. See question 170.
United Kingdom. Carbon tetrachloride-tricholoromethane.

HEPATOTOXIC EFFECTS

Note that malignant diseases are addressed in questions 97-100. Do NOT consider them here.

183. Please specify below the causative agents/exposures which are mentioned for hepatotoxic effects (e.g. toxic liver disease) in your national list of OD

Austria. Reference is made to the following items of the national list: BK2 (Phosphorus and compounds), BK4 (Arsenic and compounds), BK6 (Cadmium and compounds), BK8 (Chromium and compounds), BK9 (Benzene and homologues), BK10 (Nitro- and aminoderivatives of benzene etc.), BK11 (Halogenated hydrocarbons), BK49 (Nickel and compounds) BK51 (Halogenated alkyl-, akryl- or alkylaryloxides), BK52 (polyneuropathy and encephalopathy due to organic solvents or their mixtures).
Belgium. Toxic hepatitis caused by chemicals etc. can be identified according to the code of national list and the ICD code. No agents are mentioned in the questionnaire.
Denmark. Arsenic, acrylonitrile, chlorinated solvents, infectious diseases.
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Hepatotoxic effects are specifically mentioned under the following items: Phosphorus and its compounds, Lead and its compounds, Nitro and amino derivatives of hydrocarbons, amines, Phenol and its homologues and their halogen and nitro derivatives
France. Hepatotoxic effects due to chemical agents are mentioned in 6 of the national tables. These include about 30 chemicals or groups of chemicals.
Germany. Dimethylformamide.
Ireland. Infection by leptospira, viral hepatitis, non endemic infectious or parasitic diseases.
Italy. There is no list of causative agents for hepatotoxic effects, but such disorders may be included under many agents mentioned in the list.
Luxembourg. Chemicals.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Portugal. Toluene and phenol and their nitrate compounds. Aromatic amines and carbon tetrachloride.
Spain. Hepatotoxic effects are not specifically mentioned, but may be included under many of the chemicals mentioned in the list.
United Kingdom. C24b – Non-cirrhotic portal fibrosis, caused by work in or about machinery or apparatus used in the polymerisation of vinyl chloride monomer. C26 – Damage to liver or kidneys due to exposure to Carbon Tetrachloride. Prescribed disease C27 – Damage to liver or kidneys due to exposure to Trichloromethane (Chloroform).

184. In addition to the agents in your national list, does your national system include a possibility of recognising hepatotoxic effects caused by other causative agents ?

No: Ireland, United Kingdom
Yes: Austria, Belgium, Denmark, Finland, France, Germany, Italy, Luxembourg, The Netherlands, Portugal, Spain

185. Are cases of hepatotoxic effects recognised also under more general items of your national list (e.g. poisonings in general)

No: Austria, Denmark, Ireland, Italy, Portugal
Yes: Belgium, Finland, France, Germany, Luxembourg, Spain, United Kingdom

186. If YES in 185, can you identify cases of hepatotoxic effects separately under such items of your national list ?

No: Finland, Italy, Spain, United Kingdom.
Yes: France, Germany, Luxembourg

187. If NO in 186, please specify below the causative agents/exposures for which you can't separate hepatotoxic effects from other toxic entities in your national registry

Finland. If a hepatotoxic effect is part of a more general poisoning, it can probably not be identified as a separate entity.
The Netherlands. See question 183.
Spain. See question 170.
United Kingdom. Carbon tetrachloride – trichloromethane – chlorinated naphthalene

BENIGN HAEMATOLOGICAL DISORDERS

Note that malignant diseases are addressed in questions 97-100. Do NOT consider them here.

188. Please specify below the causative agents/exposures which are mentioned for benign haematological disorders in your national list of OD

Austria. Reference is made to the following items of the national list: BK1 (Lead and compounds), BK2 (Phosphorus and compounds), BK3 (Mercury and compounds), BK4 Arsenic and compounds), BK8 (Chromium and compounds), BK9 (Benzene and homologues), BK10 (Nitro- and aminoderivatives of benzene etc.), BK11 (Halogenated hydrocarbons), BK13 (Carbon sulphide), BK49 (Nickel and compounds).
Belgium. Benign haematological disorders caused by chemicals etc. can be identified according to the code of national list and the ICD code. No agents are mentioned in the questionnaire.
Denmark. Not specifically mentioned in the national list.
Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. Benign haematological disorders are specifically mentioned under the following items: Lead and its compounds, Nitro and amino derivatives of hydrocarbons, amines and methaemoglobinanaemia, Trinitrotoluene and haemolytic anaemia, Phenol and its homologues and their halogen and nitro derivatives and methaemoglobinanaemia and haemolytic anaemia
France. Different kinds of benign haematological disorders are mentioned in 16 of the national tables. These include about 20 chemical or biological agents and ionising radiation.
Germany. -
Ireland. Not applicable.
Italy. There is no list of causative agents for haematological disorders, but such disorders may be included under many agents mentioned in the list.

Luxembourg. Chemicals.
The Netherlands. There is no national list of OD. The reporting criteria are based on "Information notices on diagnosis of occupational diseases".
Portugal. Lead, benzene, toluene, xylene, phenol, aromatic amines, phenylhydrazine and vinyl chloride.
Spain. Benign haematological disorders are not specifically mentioned, but may be included under many of the chemicals (following European List) mentioned in the list.
United Kingdom. Poisoning by lead.

189. In addition to the agents in your national list, does your national system include a possibility of recognising haematological disorders caused by other causative agents ?

No: Ireland, United Kingdom
Yes: Austria, Belgium, Denmark, Finland, France, Italy, Luxembourg, The Netherlands, Portugal, Spain

No answer: Germany

190. Are cases of haematological disorders recognised also under more general items of your national list (e.g. poisonings in general)

No: Austria, Belgium, Denmark, Ireland, Italy, Portugal
Yes: Finland, France, Germany, Luxembourg, Spain, United Kingdom

191. If YES in 190, can you identify cases of haematological disorders separately under such items of your national list

No: Finland, Ireland, Italy, Spain, United Kingdom
Yes: France, Germany, Luxembourg

192. If NO in 191, please specify below the causative agents/exposures for which you can't separate haematological disorders from other toxic entities in your national registry

Finland. If haematological disorders are part of a more general poisoning, it can probably not be identified as a separate entity.
The Netherlands. See question 183.
Spain. See question 170.
United Kingdom. Lead or a compound of lead.

INTOXICATIONS/POISONINGS

193. Several chemicals may cause acute or subacute poisonings. Depending on the chemical and its concentration these poisonings may differ a lot in duration of exposure and latency period between exposure and clinical manifestation. Some of these poisonings may therefore be classified also as accidents at work. Please explain below how your national system defines which of the acute poisonings are recognised as occupational diseases and which ones as accidents at work.

Belgium. Accident at work: a sudden event. Occupational disease: A result of a prolonged exposure to a known risk factor. Nevertheless in the private sector, a disease occurring on the national list of OD may be recognised even after a sudden event if it were rejected as an accident at work.
Denmark. Acute poisonings are classified as accidents at work when they occur as a consequence of a sudden, external event, for instance a leakage of a very poisonous substance which causes immediate symptoms.
Finland. The borderline has not been clearly defined. If the exposure is instantaneous, the condition is usually coded as an accident, but not necessarily (e.g. RADS). From the point of view of the worker it makes no difference, because both ODs and accidents at work are covered by the same system.
France. Occupational disease: prolonged exposure. Accident at work: sudden, unusual exposure.
Germany. If the substance is on the list , the case is normally treated as an occupational disease; if not, it is treated as an accident.
Ireland. Recorded as an accident if a once off accident or a short acute contact with the substance is involved, usually not more than a few days. If the case is outside this criteria it is examined to see if it can be accepted as an OD.
Italy. The difference between disease and accident depends on the duration of exposure: in the first the exposure is extended, in the second it must be very short, no more a duty
Luxembourg. In general, acute poisoning is declared as an accident at work
The Netherlands. All irritative effects, which are not noticeable immediately after the incident (some hours), are to be notified as occupational diseases. The irritative effect has to be of clinical importance or lead to impairment or incapacity.
Portugal. If symptoms start suddenly after acute exposure to an unusual high concentration of a causative chemical agent, the situation will be considered as an accident at work. If the symptoms start progressively after a chronic exposure the situation will be considered an occupational disease.
Spain. In general, acute poisoning is declared as an accident at work
United Kingdom. There is no legislation to specify this. Rather, since the Workmen's' Compensation Act of 1897, the courts have defined the nature of an accident, and how it differs from a gradual cause of a problem (process). In general, a subacute poisoning which involved exposure to the poison over a defined and relatively brief period of time, or on a small number of such occasions, could be accepted as an accident. Otherwise, a claim could only be made if the poisoning was a prescribed disease.

CARDIOVASCULAR DISEASES

194. Please list below all the cardiovascular diseases which are specifically mentioned in your national list of OD

None: Belgium (except vibration effects), Denmark (except vibration white finger), Germany, Ireland, Luxembourg, Portugal
Finland. The occupational disease system is open, i.e. any causative agent or disease is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. The following cardiovascular effects are specifically mentioned: 1.Carbon disulphide and coronary artery disease, 2.Freon and cardiac arrhythmia, 3. Nitroglycerol and nitroglycol and blood pressure effects, 4. Cardiovascular complications of pneumoconioses
France. Acute hearth insufficiency, changes in blood pressure, precardiac pain, pericardiac lesions, endocardiac lesions, myocardiac lesions and cardiac arrhytmias are mentioned under various chemicals or microbiological agents
Italy. No cardiovascular diseases are specifically mentioned but the may occur in relation to some of the chemicals mentioned in the list.
The Netherlands. No recognition scheme, reporting according to the "Information notices".
Spain. Cardiovascular diseases are not specified in the list, but could be included under some of the chemicals in the list.
United Kingdom. The only one is cardiac disease arising as a result of exposure to Carbon bisulphide.

MENTAL AND BEHAVIOURAL DISORDERS

195. Please list below all the mental and behavioural disorders which are specifically mentioned in your national list of OD

None: Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, Portugal, Spain

Austria. Reference is made to item 52 of the national list (list not attached)
The Netherlands. Post traumatic stress disorder and burnout are included in the reporting scheme.
United Kingdom. Mercurial erethism

BORDERLINE TO NON-DISEASE CONDITIONS

196. In some countries, some exposure-related "non-disease" conditions may be eligible for financial reimbursement from the same compensation scheme as occupational diseases. Is any of the following events recorded into the same statistical system as recognised occupational diseases in your country ?

	B	DK	D	E	F	IRL	I	L	A	P	FIN	UK
Leave or other consequence of immunologic testing, which did not finally reveal any disease (e.g. tuberculosis testing)	+											
Leave due to increased serum level of lead (no disease or symptoms present), which necessitates the exposed worker to retain from exposure in order to reduce the serum level	+									+		
Leave due to a preventive vaccination (no disease or symptoms present)												
Leave due to side-effects of prophylactic medication (no disease or symptoms present)												

No recognition scheme in NL, reporting according to "Information notices"

197. If any of the above (question 196) or related non-disease conditions are dealt by the same compensation scheme as occupational diseases, please comment below whether you can distinguish these non-disease conditions from the occupational diseases in your national data system.

Belgium. Not possible at the moment.

ANTICIPATED CHANGES AND ALTERNATIVE REPORTING SCHEMES

198. Please specify below, if you anticipate any changes in your national system before the year 2001 concerning the issues addressed in this questionnaire

Belgium. New entities will be included: 1.701 Allergic diseases due to latex, 9.310 Cancer of the larynx related to asbestos (either in combination with asbestosis/diffuse pleural thickening or exposure to asbestos of at least 25 fibre-years).
Finland. The national list of OD is currently under revision. The following new items have been suggested to be included : l. Lung cancer and exposure to silica, 2. Carpal tunnel syndrome, 3. Hepatitis C.
Italy. A new law and list for the assessment of severity of diseases are in force since 25/07/2000. See details on next page.
Luxembourg. The national list may possibly be updated.
Portugal. Besides other changes, the law coming into force on January 2000 recognises that in cases of permanent partial disabilities inferior to 30% will be paid a lump sum of a life annual pension corresponding to 70% of the reduced general capacity of gain, calculated on a basis that will be ruled. It recognises also the payment of a lump sum in the case of pensions allowed corresponding to a permanent partial disability inferior to that degree (30%), or of a small amount. Nevertheless this matter is not yet ruled.

United Kingdom. The Industrial Injuries Advisory Council, an independent statutory body which advises the Secretary of State for Social Security on the UK Industrial Injuries Scheme and in particular on the prescription of diseases for the purpose of claim to benefits, is currently undertaking a long term review of the schedule of prescribed occupational diseases, to ensure that the prescription of these diseases continue to reflect scientific knowledge. It is likely that changes will be made to the list as a result.

Italy – details on the new system from 25/07/2000 :
"The legislation on economic compensation awarded by INAIL for permanent damage caused by an accident at work or an occupational disease has recently been amended - by Mr. Mario Maci INAIL.
An important amendment has recently been made to the current Italian legislation concerning the economic compensation INAIL awards to insured workers as an indemnity for permanent damage caused by accidents at work or occupational diseases.
To date, INAIL has granted monthly benefits, which were calculated on the basis of the insured monthly wage and according to the degree of disability, that is, the reduced ability to pursue gainful employment. The pension was awarded for disabilities with a level equal to or higher than 11%.
Therefore, if the impairment was lower than 11%, or if it did not reduce the ability to work (but only caused, for example, aesthetic, sexual or reproductive damage), it was not indemnified. Furthermore, if the impairment was equal to or higher than 11%, and besides the ability to work also hindered aspects such as social, emotional, cultural or sporting performances, indemnity was only granted for the inability to work.
Therefore, thus far, indemnified damages were only related to a person's ability to generate income through work. In other words, compensation was only awarded for lost earnings.
Now, thanks to the *Reform of accidents at work and occupational diseases insurance (delegation to the Government) Act 1999* and to the *Accidents at work and occupational diseases insurance (Amendment) Regulations 2000*, INAIL indemnities cover any permanent damage of more than 5% affecting the mental and physical integrity of the worker, even if the injuries do not result in a loss of earnings.
Hence, both Parliament and the Government have put into practice a principle that is anchored in the Italian Constitution by which a person's mental and physical integrity, that is, their health, is viewed as a basic right as well as a common good for society. Therefore, any damage to health caused by an accident at work or an occupational disease must be indemnified as it diminishes the abilities that allow a person to express their personality through different aspects of life (emotional, social, political, cultural, religious, sports, etc.).
The following rules have been adopted by the Government to indemnify health impairments:
- for damage less than 6% no indemnity is granted, as it is considered too minor for social protection within the system run by INAIL;
- from 6% to 15% an indemnity is granted by award of a lump sum; the amount may be raised, though only once, in the event that the health impairment worsens;
- from 16% to 100% the indemnity is awarded by transforming the capital value into a monthly pension for life, and because such impairments are more severe the Government has judged it necessary to award such economic indemnity as whole-life support. In the event that a person's health deteriorates, the benefits may be raised – as already the case in the past – following periodic reviews.

The indemnity for health impairments is proportional to the damage (the worse the damage the higher the indemnity) and to the age of the injured person (the younger the injured worker the higher the indemnity). The indemnity, however, does not take into consideration the worker's wage, as the impairment is treated in the same way for every person whatever their previous earnings.
As mentioned above, damage to health is indemnified even if there are no consequences for the worker's ability to follow a gainful occupation, that is, if the health impairment does not result in financial losses. But when this loss exists, it also has to be considered and indemnified.

Therefore, the Government has stated that when the health impairment exceeds the threshold of 15%, it has to be "presumed" that it will also have consequences for the person's ability to generate income through work; from 16% and up to 100%, compensation has to be awarded not only for the damage to health but also for the income loss the impairment causes a worker.
These consequences for earnings are evaluated and indemnified using criteria fixed in law; such criteria consider four possibilities:

- either the worker may continue to pursue a previous occupation, even if associated with greater difficulties;
- or s/he has to leave the previous job but may be able to pursue a similar occupation;
- or s/he may pursue merely part-time activities consistent with the disability, frequently thanks to rehabilitation programmes or support provided in the workplace and other aids;
- or, finally, s/he may be incapable of any form of work.

Compensation for lost earnings is provided in line with the seriousness of the disability. Therefore, the greater the impairment to the worker's ability to generate income through work the higher the indemnity.
The indemnity for lost earnings, in addition to the indemnity for health impairment, is also awarded as a whole-life, monthly pension.
Tables for the valuation of biological damage (understood not as biological agent) and for assessment of severity of all diseases and of accidents at work are available in INAIL."

199. Please comment/list below additional/alternative occupational disease reporting schemes which are used in your country. Please indicate which diseases are concerned in these schemes, what are the reporting criteria, who reports, what is the geographical, industrial etc. coverage of the reporting scheme.

No comments were presented.

PART 3 - NAMES AND AFFILIATIONS OF THE NATIONAL RESPONDENTS.

Austria (AUVA) Ruzicka Peter Allgemeine Unfallversicherungsanstalt Adalbert Stifterstr. 65 A-1200 Wien	France. Mr. Pierre Lardeux CNAMTS 33 avenue du Maine F-75755 Paris Cedex 15	The Netherlands. Mr. Leen van Vliet Ministry of Social Affairs and Employment P.O. 90801 2509 LV Den Haag Netherlands
Austria (SVB) Taferner Johannes SVB A-1031 Wien, Ghegastraße 1 Austria (Railways) Lucia Rotter Versicherung der österreichischen Eisenbahnen A-1061 Wien Linke Weinzeile 48-52	Germany. Andreas Horst, BMA and Dr. Martin Butz, HVBG D-53754 Sankt Augustin	Portugal Centro Nacional de Protecção contra os Riscos Profissionais Maria Lucilia Leal Pires Farias Divisão de Assuntos Internacionais Av. da República, 25 – 1.º Esq. 1069 036 LISBOA Portugal
Belgium Danielle De Brucq Ministère des Affaires Sociales Rue de la Vierge Noire, 3c B-1000 BRUXELLES	Ireland. Jim Heffernan Health and Safety Authority 10, Hogan Place, Dublin 2 Ireland	Spain Marta Zimmermann Instituto Nacional de Seguridad e Higiene en el Trabajo Torrelaguna 73, 28027 Madrid. España
Denmark Karin Holst Jensen, Head of Department	Italy. Dr. Daniela Germani INAIL Sovrintendenza Medica Generale Piazzale Pastore 6 I-00144 Roma Italy	Sweden Mr. Peter Jusélius and Mr. Rolf westin National Social Insurance Board S-10351 Stockholm Sweden
Finland. Dr. Antti Karjalainen Finnish Institute of Occupational Health Topeliuksenkatu 41 aA FIN-00250 Helsinki FINLAND	Luxembourg. Jean-Paul DEMUTH, Premier Conseiller de Direction 125, rte d'Esch L-1471 Luxembourg	United Kingdom Mr M McGill Department of Social Security Room B2612 Benton Park Road Newcastle England NE98 1YX

PART 4 - GLOSSARY.

The questionnaire contains some key terms which may not be explicit enough as such. These terms are explained below. The terminology may not be generally accepted and you should bear in mind that the explanations refer only to what is meant by these terms in this questionnaire.

Physiological impairment. Physiological impairment refers to the clinical severity of the disease. It can be assessed with physiological tests and clinical findings, but it does not take into account the socio-economic impact of the disease. The *degree of physiological impairment* is a quantitative index which gives the level of physiological impairment.

Recognised occupational disease. A disease which is administratively accepted as an occupational disease. A *recognised case of OD* is a case which is administratively accepted as an occupational disease.

Work disability. Work disability refers to a reduction in the working ability of the individual which is due to his/her disease. In addition to the disease itself, the assessment of the work disability takes into account the consequencies the disease has (or is estimated to have) on the individual's earnings. The *degree of work disability* is a quantitative index which gives the level of reduction in the individual's working ability which is attributed to his/her occupational disease.

PART 5 - ABBREVIATIONS OF THE COUNTRIES.

Country	**Abbreviation**
Belgique/Belgïe	**B**
Danmark	**DK**
Deutschland	**D**
Ellada	**EL**
España	**E**
France	**F**
Ireland	**IRL**
Italia	**I**
Luxembourg	**L**
Nederland	**NL**
Österreich	**A**
Portugal	**P**
Suomi/Finland	**FIN**
Sverige	**S**
United Kingdom	**UK**

PART 6 - ANSWERS OF QUESTIONS 97.

97. Please list below all pairs of cancer (site/type of cancer and causative agent) which are specifically mentioned in your national list of occupational diseases (e.g. sinonasal cancer caused by nickel compounds). Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list. Please list also haematological malignancies.

Austria. Reference is made to the following points of the national list. The cancer sites are not specified:
BK4 Arsenic and compounds
BK6 Cadmium and compounds
BK7 Beryllium and compounds
BK8 Chromium and compounds
BK9 Benzene and homologues
BK16 Ionising radiation
BK17 Skin cancer and soot, crude paraffin, tar, anthracene, pitch or similar substances
BK18 Bladder cancer and aromatic amines
BK45 Nasal adenocarcinoma and wood dust
BK49 Nickel and compounds
BK51 Halogenated alkyl, akryl alkylaroxide compounds

Belgium.
Mesothelioma and asbestos
Respiratory tract cancer and wood dust
Lung cancer and asbestos

Denmark.
Asbestos and mesothelioma, lung cancer and cancer of the larynx
Arsenic: skin and lung cancer
Chromium: lung cancer
Nickel: lung cancer
Benzene: myeloid leukaemia
2-Naphtylamine: bladder cancer
Skin cancer: soot, tar, tarry asphalt, pitch, anthracene, mineral oils, crude paraffin and compounds and residue connected with such substances

Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. The following agent-cancer pairs are specifically mentioned:
Ionizing radiation and skin cancer
Ionizing radiation and bone marrow damage
Arsenic and its compounds and skin cancer
Arsenic and its compounds and lung cancer
Beryllium and its compounds and lung cancer
Cadmium and its compounds and lung cancer
Chromium and its compounds and lung cancer
Chromium and its compounds and sinonasal cancer
Nickel and its compounds and sinonasal cancer

Nickel and its compounds and lung cancer
Benzene and leukaemia
Vinyl chloride and hemangiosarcoma of the liver
Aromatic amines and bladder cancer
Ethylene oxide and leukaemia
Polychlorinated biphenyls and liver cancer
Cancer drugs and leukaemia
Cancer drugs and lympho-haematopoietic malignancies
Cancer drugs and bladder cancer
Asbestos and mesothelioma and lung cancer
Aflatoxins and cancer of the liver

France.
Various agents are mentioned for the following cancers
1. Skin cancer
2. Sarcoma
3. Lung and pleura
4. Bladder cancer
5. Brain cancer
6. Mesothelioma
7. Angiosarcoma
8. Leukaemia

Germany.
Urinary tract – aromatic amines
Respiratory tract/lungs – nickel and its compounds
Respiratory tract/lungs - raw coke-oven gases
Adenocarcinoma of the nasal orifices and nasal sinuses – oak dust/beech dust
Skin – soot, crude paraffin, tar, anthracene, pitch or similar substances
Asbestos and mesothelioma, lung cancer and cancer of the larynx

Ireland.
1. Carcinoma of the nasal cavity or associated air sinuses caused by manufacture /repair of wooden goods, leather or fibreboard.
2. Angiocarcoma of the liver caused by polymerisation of VCM
3. Carcinoma of the mucous membrane of the nose or associated air sinuses or primary carcinoma of a bronchus or of a lung where Ni is produced by decomposition of a gaseous Ni compound.
4. Squamous- celled carcinoma of the skin due to use or handling of arsenic, tar,pitch,bitumen,mineral oil, soot or any compound,product or residue of these substances except quinone or hydroquinone.
5. Primary neoplasm of the epithelial lining of the urinary tract due to alpha or beta-naphthylamine, methylene –bis- orthochloroaniline, diphenyl substituted by at least one nitro or primary amino group or by at least one nitro and primary amino group etc., salts of any of th above, auramine or magenta.

Italy.
Only some cancers are mentioned in our list: see industrial list n. 56,57,58. INAIL can recognize cancers related with causative agents in its list wich are included by IARC, in the group one.

Luxembourg.
Chemical agents
Nickel

Nasal adenocarcinoma due to dusts
Skin cancer due to soot, crude paraffin, minerail oil... or other carcinogenic substances

The Netherlands. There are criteria for registration in order to improve the quality of the data. These are based on the Information Notices. These criteria are only available in Dutch (website NCvB: www.beroepsziekten.nl. See: 'richtlijnen').

Portugal. The causative agents mentioned in our national list are the following ones:

AGENTS	CANCERS
Aminobifenyl:	bladder cancer
Arsenic and related compounds:	skin, lung and liver
Auramine:	bladder
Benzene:	hematopoietic cancer
Benzidine:	bladder
Bis (chloromethyl) ether	lung
Chromium and related compounds	lung and sinonasal
Hematitis	lung
Isopropyl alcohol	larynx and sinonasal
Mustard gas	larynx and lung
Naphtylamine	bladder
Nickel	sinonasal, lung
Tar, oils	lung, skin, bowel
Vinyl chloride	liver, lung, brain
Ionising radiation	depending on the part of irradiated body
Acrylonitril	lung, bowel
Aflatoxins	liver
Amitrole	several cancers
Beryllium	lung
Cadmium and related compounds	prostate, lung
Carbon tetrachloride	liver
Dimethyl-carbamoyl chloride	lung
Dimethyl sulphate	lung
Ethylene oxide	hematopoietic system, stomach
Nickel and related compounds	sinonasal, lung
Binaphyl polychlorades	skin

Spain.
Sinonasal, bronchial or lung cancer caused by nickel.
Sinonasal, larynx , bronchial or lung cancer caused by chromium.
Liver angiosarcome caused by vinyl chloride.
Haematopoyetic cancer caused by benzene and its derivatives.
Skin, bronchial, lung and liver cancers caused by arsenic.
Bladder and kidney cancers caused by naftylamine, difenico, auramine, magenta, bendidine.
Skin, lung, bone, and marrow cancers caused by ionising radiation.
Skin cancer caused by paraffin, tar, soot.

United Kingdom.
1. Malignant disease of the skin or blood dyscrasias due to electromagnetic radiations (other than radiant heat) or to ionising particles.
2. Poisoning by arsenic (includes carcinoma of lung)
3. Poisoning by benzene or homologue of benzene (includes acute non lymphatic leukaemia)

4. Squamous celled carcinoma of the skin – the use of/handling of/exposure to arsenic, tar, pitch, bitumen, mineral oil (including paraffin), soot or any compound, product or residue of any of these, except quinone or hydroquinone.
5. Carcinoma of the mucous membrane of the nose or air sinuses – work in a factory where nickel is produced by decomposition of a gaseous nickel compound which necessitates working in or about a building or buildings where that process or any other industrial process ancillary or incidental there to is carried out.
6. Primary carcinoma of a bronchus or lung – nickel as for carcinoma of the mucous membrane of the nose.
7. Primary neoplasm (including carcinoma in situ and invasive carcinoma) of the epithelial lining of the urinary tract (renal pelvis, ureter, bladder and urethra). Work in a building producing – alpha-naphthylamine or methylene-bisorthochloroaniline; diphenyl substituted by at least one nitro or primary amino group or by at least one nitro and primary amino group (including benzidine). Auramine or magenta. Exposure to coal, tar, pitch, volatiles produced in aluminium smelting involving the Soderberg.
8. Angiosarcoma of the liver – vinyl chloride.
9. Diffuse mesothelioma – asbestos.
10. Nasal carcinoma – wood, wooden goods manufacture/or repair: manufacture of footwear (or components) made of leather or fibre board: repair of footwear.
11. Primary carcinoma of the lung – where there is accompanying asbestosis and/or diffuse pleural thickening – asbestos.
12. Primary carcinoma of the lung – underground in a tin mine: bis (chloromethyl) ether: zinc chromate, calcium chromate, strontium chromate.
13. Primary carcinoma of the lung – where there is accompanying silicosis – silica dust in glass, pottery manufacture: tunnelling: mining metal ores: slate quarrying: mining clay: abrasives: cutting stone: stone masonry: foundry.

PART 7 - ANSWERS OF QUESTIONS 119.

119. Please list below all the infectious diseases (including parasitic diseases) which are specifically mentioned in your national list of occupational diseases. Even if only broad categories are mentioned in your national list, please list them below in the manner they are mentioned in the national list.

Austria. Reference is made to the following itmes of the national list:

BK36 (ankylostomiasis and Strongyloides stercoralis),
BK37 (Tropical diseases),
BK38 (Incetious diseases),
BK39 (Infectious diseases transmitted by animals),
BK46 (Infectious diseases transmitted by tick bites).

Belgium.

1.401 parasitic diseases: Ankylostomiasis (1.401.01) anguillule (1.401.02)
1.402 tropical diseases: malaria, amoebiasis
1.403.01 infectious or parasitic diseases transmitted by animals
1.403.02 tetanus
1.403.03 hepatitis A in workers exposed to waste water or fecal material
1.404.01 tuberculosis in health care workers
1.404.02 viral hepatitis in health care workers
1.404.03 other infectious diseases in health care workers

Denmark.

D1. Infectious diseases transferred to humans by animals or animal material. Same diaseases caused by work in refuse disposal systems and sewage systems etc. Examples mentioned:

tetanus,
ornithosis,
undulant fewer,
anthrax,
Weil's disease,
tuberculous infection from animals

D2. Infectious diseases in persons who, as part of their work, have been in contact with blood, tissue, tissue fluids or other biological material from patients/persons with the same type of infection. Examples mentioned:

hepatitis,
staphylococci,
tuberculosis,
AIDS

D3. Tropical diseases such as:

malaria,
amoebiasis,
trypanosomiasis,
dengue fever,
pappataci fever,
Malta fever,
relapsing fever,
yellow fever,
plague,
leishmaniosis,
framboesia,

leprosy,
spotted fever and other fever diseases caused by ricketssia

Finland. The occupational disease system is open, i.e. any causative agent is relevant if there is adequate evidence of the causation. The ordinance on occupational diseases (1347/88), however, lists 6 physical factors or groups, 36 chemical factors or groups and 3 biological factors or groups. Under each of the items, there are examples of typical forms of disease. The following infections are specifically mentioned under the following items:
1. Tuberculosis, 2. Viruses, bacteria, fungi, protozoa and schistosomes (e.g. hepatitis B, milker's nodules, erysipeloid, brucellosis, anthrax, listeriosis, skin mycosis, toxoplasmosis, malaria, bilharzia)

France.

Amoebiasis
Ankylostomiasis
Brucellosis
Anthrax
Cholera
Shigellosis
Enterobacteriosis
Erysipeloid
Hemorrhagic fevers (Lassa, ebola, Marburg, Congo-Crimée)
Typhoid and paratyphoid fever
Q Fever
Gonococcal disease (cutaneous and its articular complications)
Hantavirus infection
Hepatitis A, B, non-A non-B
Viral keratoconjunctivitis
Leptospirosis
Lyme disease
Meningococcal diseases
Mycosis
Pasteurellosis
Pneumococcal disease
Pseudomonas aeroginosa infection
Psittacosis
Rabies
Rickettsiosis
Rouget de porc
Salmonellosis
Staphylococcal disease
Streptococcus suis infection
Streptoccal disease (beta-hemolytic)
Syphilis (primary cutaneous)
Tetanus
Tuberculosis
Tularemia

Germany.

Infectious diseases in the health service, in social welfare, in laboratories or in the case of activities presenting similar risks
Diseases that are transferable from animals to humans

Worm infections of miners caused by Ankylostoma duodenale or Strongyloides stercoralis
Tropical diseases, typhus

Ireland.

anthrax,
glanders,
infection by leptospira,
infection by organisms of the genus brucella,
streptococcus suis,
tuberculosis,
viral hepatitis
non endemic infectious or parasitic diseases not endemic in the state eg malaria

Italy. The only infection disease mentioned in our list is ancylostomiasis (I.n.55, A. n.1). The other infectious diseases are recognised as accidents at work.

Luxembourg.

No specific infections were mentioned in the questionnaire

The Netherlands. No recognition scheme for ODs, reporting according to "Information notices"

Portugal.

tetanus,
brucellosis,
tuberculosis of lung, pleura, skin, lymphatic nodes, synovitis and osteoarthritis
carbuncles
ricketsiosis
meningitis
scarlet fever
streptococcal tonsillitis, rhino pharingitis,
erysipela,
diphtheria,
staphylococcal diseases,
salmonelloses,
rabies,
hepatitis
poliomyelitis
trachoma
rubella
measles
parothiditis
leptospirosis disease
amoebiasis ,acute and sub-acute intestinal and hepatic
ancylostoma,
dermatophitic disease (head and nails),
candidiasis,
sporotrichosis,
mycetoma,
cryptococcal disease
biological agents in tropical diseases

Spain.

carbuncles
tetanus
leptospirosis
brucellosis
tularemia
tuberculosis
ankylostomiasis
malaria
viral hepatitis
infections transmitted from contact with patients or laboratory activities

United Kingdom. Prescribed diseases:

B1 – anthrax;
B2 – glanders;
B3 – infection by leptospira;
B4 - ankylostomiasis
B5 – tuberculosis;
B7 – infection by organisms of the genus brucella;
B8 – viral hepatitis;
B9 – infection by streptococcus suis;
B10a – avian chlamydiosis;
B10b – ovine chlamydiosis;
B11 – Q fever;
B12 - Orf ;
B13 - hydatidosis