THE OCCUPATIONAL HEALTH CRISIS IN ISRAEL

2021

קו לעובד
Worker's Hotline
عنوان العامل

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Executive Summary

The number of workers who die due to occupational diseases is higher than those who die due to work accidents. According to the International Labor Organization (ILO), 2.78 million workers in the world die each year from injuries and work-related illnesses, of which 86% die from occupational diseases (and the rest from occupational accidents). However, the issue of occupational health is absent in the public and institutional agenda and does not receive as much attention in the media as do occupational accidents.

The number of workers affected by occupational diseases is underestimated – the number of workers affected by occupational diseases is underestimated in Israel and around the world. The Adam Committee report refers to ILO estimates regarding the number of casualties from occupational diseases in Israel. The estimates indicate that there are tens of thousands of workers each year who contract occupational diseases and about 1,700 of them die every year as a result of an occupational disease. However, the report published by the Registrar of Occupational Diseases in 2019, indicates that there were 172 cases of verified patients that were reported by occupational physicians. In addition, 1876 additional cases were recognized by the National Insurance Institute.

Resources for research and enforcement are insufficient - there is a shortage of resources and manpower in every aspect of occupational health policy, including research, monitoring and enforcement. For example, there are only a small number of occupational physicians, who are a major source of information regarding occupational diseases and the primary point of contact for workers. In 2020, the number of occupational physicians in Israel stood at about 90 active physicians, which is 0.3% of all physicians. The workforce in Israel includes about 4.1 million workers and since 99.4% of all reported cases of occupational diseases are reported by occupational physicians, the scarcity of occupational physicians explains the low number of reported cases. The lack of resources is also apparent when it comes to enforcement. The Occupational Safety and Health Administration employs only 100 inspectors who are expected to enforce all occupational safety and health laws and regulations in Israel. However, in the last two year there was not even one occupational physician in the Administration. Most of their enforcement activity is focused on occupational safety and, consequently, the supervision of occupational diseases in Israel is extremely poor.

Many population groups are under-represented in occupational health statistics - ILO reports show that those populations most vulnerable to occupational diseases are also the populations about whom information is usually missing. Such populations include informal workers, workers of small and medium-sized employers and rural workers. In addition, increased competition and commonly used flexible employment patterns, such as temporary jobs, part-time jobs or “zero-hour” contracts, also make it difficult to collect data

on the actual extent of occupational diseases.[1] The data for Israel provided by the Registrar of Occupational Diseases and the ILO indicates that there is an under-representation of women, workers of small and medium-sized employers and informal workers, compared with an over-representation of cases reported among professional workers (55%) and workers employed in large entities with over 50 employees (66%). The over-representation is particularly prominent with employers who can afford to have an in-house clinic that provides a comprehensive solution to occupational health problems.

Recommendations not implemented– reports submitted to the relevant authorities include clear recommendations for reform obtained in consultation with many recognized experts in the field of occupational health. In practice, despite the resources invested in researching and formulating these recommendations, most of them are not implemented.

1 The Prevention of Occupational Diseases, p. 7

Chapter 1

Introduction to Occupational Safety and Health (OSH) - The Normative Framework

According to a 2017 estimate, over 2.78 million workers worldwide die from injuries or illnesses related to their work each year. In addition, about 160 million workers suffer from fatal or non-fatal occupational diseases each year.[2] This data is of concern to both international and local occupational safety and health institutions who seek to prevent and monitor health risks in the workplace worldwide.

According to the International Labor Organization (ILO), occupational safety and health (OSH)[3] comprises two main areas: accidents and injuries as well as occupational diseases. Protocol 155 of the 1981 Occupational Safety and Health Convention defines a work accident as "an occurrence arising out of, or in the course of, work which results in fatal or non-fatal injury."[4] An occupational disease, on the other hand, refers to "any disease contracted as a result of an exposure to risk factors arising from work activity."[5] According to information published by the International Labor Organization in 2013 (based on 2011 data) occupational diseases account for 86% of the 2.34 million deaths in the workplace worldwide due to either occupational diseases or occupational injuries.[6] This amounts to about 2.02 million deaths due to occupational diseases, as of the date of publication.[7] However, as noted above, according to a more recent estimate published by the ILO in 2017, the number of deaths resulting from occupational diseases or injuries increased to 2.78 million workers per year. In addition, in 2018 the ILO reported that non-fatal occupational diseases affected 160 million workers every year.[8]

Various local and international governmental and non-governmental bodies deal with occupational safety and health. One international body is the International Labor Organization, which was established in 1919 as a United Nations organization representing governments, employers and workers. Since its establishment, the ILO has worked to "protect workers from diseases and injuries arising out of their work."[9] The formulation of ILO conventions involves governments as well as employer and worker organizations from all member states

2 ILO report, August 2017
3 See report of the IIOSH
4 See link in the ILO website
5 P155 – Protocol of 2002 to the Occupational Safety and Health Convention, 1981, article 1; The Prevention of Occupational Diseases, see p. 4; List of Occupational Diseases (revised 2010), see p. 7.
6 The Prevention of Occupational Diseases; Zero Fund, ILO, p. 2
7 The Prevention of Occupational Diseases, p. 4, footnote 1
8 The Prevention of Occupational Diseases, see p. 4
9 Preamble to the ILO Constitution

in a tripartite process aimed at creating international norms of conduct based on broad consensus. When a convention is adopted by the ILO assembly, member states may ratify the convention and enact binding domestic legislation based on the convention.[10] Since its inception, the ILO has adopted dozens of conventions or international recommendations on occupational safety and health, of which Israel has ratified a handful.[11] In 2017, the ILO started reviewing its conventions, including those related to occupational safety and health, to ensure that they are not outdated and are still relevant to member states' legislation and reflect desired international norms.[12] More than any other organization, the ILO continues to provide practical and technical recommendations regarding the implementation of conventions adopted by member states.

There are many other international bodies working to promote the health and safety of workers. For example, the World Health Organization (WHO) is making efforts to improve occupational health in general and prevent occupational diseases in particular. The WHO releases information to health professionals worldwide regarding specific risk factors such as lead, mercury and asbestos, as well as information on the prevention of specific accidents such as falling from height. The WHO also compiles statistical information on injuries and deaths due to specific occupational illnesses or occupational accidents and publishes guidelines for minimizing and reducing exposure factors. At the General Assembly of the World Health Organization, a decision was made to develop recommendations for member states and other donors regarding medical technologies and the manufacturing of medical devices designed to prevent occupational accidents and injuries.[13] Accordingly, in 2019 the WHO published its global strategy for addressing the impact of the global climate crisis on worker occupational health, particularly in those countries considered most vulnerable to the effects of climate crisis.[14]

In addition to international organizations, there are many other governmental bodies that advance occupational safety and health at the regional and local levels, such as: the European Agency for Occupational Safety and Health (EU-OSHA), the American Occupational Safety and Health Administration (OSHA), the Canadian Center for Occupational Health and Safety (CCOHS), the Health and Safety Executive in the United Kingdom (HSE), the Nordic Labor Ministers Association (NIVA), and the Israel Institute for Occupational Safety and Hygiene (IIOSH). In many cases, the scope of responsibility of these government bodies exceeds health and safety issues, and they work in partnership with other government agencies and NGOs. For example, the Occupational Safety and Health Administration, which is currently affiliated with the Ministry of Economy, also collaborates with the Israel Institute for Occupational Safety and Hygiene as well as the Ministry of Health's Occupational Diseases Registry in the

10 FUNDAMENTAL PRINCIPLES OF OCCUPATIONAL HEALTH AND SAFETY , Benjamin O. Alli, p. 9.
11 List of conventions ratified by Israel.
12 Overview document: Background information applicable to all OSH preparatory documents, ILO, 2017.
13 Health Technologies, Report by the WHO Secretariat
14 Health, environment and climate change, draft WHO global strategy

fight against occupational diseases in Israel. In addition, various non-governmental bodies may also be involved, especially labor or medical organizations, such as the Israel Society for Occupational Medicine of the Israeli Medical Association, and the National Council for Worker Safety that is appointed by the Health and Labor Ministers.

Definition of Occupational Disease

While at its core, an occupational disease is a medical phenomenon, its definition includes the cause for the disease that distinguish it from other diseases (often times it is very difficult to distinguish between an occupational disease and an identical disease that does not have occupational causes). As mentioned previously, the ILO defines an occupational disease as "any disease contracted as a result of an exposure to risk factors arising from work activity." UN organizations such as the ILO and the WHO, as well as many other governmental bodies, recognize three fundamental criteria that define occupational diseases: clinical diagnosis of an illness, exposure to risk factors in the workplace and a causal or associative relationship between the two.[15] Globalization and social and technological changes lead to increased exposure to risk factors and consequently to the emergence of new occupational diseases such as mental health problems or problems in the musculoskeletal system, on one hand, and automation processes and banning the industrial use of hazardous materials, on the other. However, in addition to the medical aspect of occupational diseases, the demonstration of the causal relation between exposure to the risk factor or activity in the workplace and the emergence of the occupational disease, is required.

Given the requirement to prove a causal link between the disease and exposure to risk factors, there is a need for expertise in analyzing the relevant data collected in the workplace and identifying its potential pathological impact. However, according to ILO reports, the populations most vulnerable to occupational diseases (i.e. informal workers, employees of small and medium-sized businesses and workers in rural areas) are often ignored when it comes to data collection. Additionally, increasingly competitive job markets and flexible employment patterns, such as temporary and part-time jobs or "zero-hour" contracts, make it even more difficult to collect data that demonstrates the extent of occupational diseases.[16]

At the global level, countries or other entities can direct efforts in their search for occupational diseases in order to identify disease trends by sector among the general population. Increased frequency of a specific disease occurring in a particular group of workers exposed to a unique risk when compared to the general population, may indicate a causal link between exposure in the workplace and the disease, thus revealing the presence of a potential occupational

15 The Prevention of Occupational Diseases, p4 .; International Statistical Classification of Diseases and Related Health Problems (ICD), p. 1; List of Occupational Diseases (revised 2010), p. 7
16 The Prevention of Occupational Diseases, p. 7

disease.[17] However, these methods require significant statistical work and meticulous recording of disease cases among the general population, as well as the use of data analysis methods by employee or exposure type. In reality, occupational safety and health entities often work on a case-by-case basis and determine the occupation-related factors for each disease separately.

In order to better diagnose occupational diseases, there is a need to investigate physical, chemical, biological and other factors linked to a relevant activity in order to identify their pathological effect.[18] While some illnesses may have a clear association with workplace exposure due to their unique nature, it is often difficult or even impossible to significantly link other more common illnesses to a particular occupational factor. Therefore, it is recognized that identifying the cause of a particular disease "is not an 'exact science,' but a matter of judgment based on a critical review of all available evidence."[19] In defining occupational disease, some states clarify that the disease must have been "contracted with sufficient certainty" as a result of exposure in the workplace.[20]

In addition to these efforts to identify occupational diseases, other entities generate lists of occupational diseases in order to facilitate easier identification. The ILO, for example, provides an updated list of occupational diseases based on meetings with experts and analysis of over 50 lists of occupational diseases formulated by various countries and occupational safety and health organizations. The ILO's list of occupational diseases is intended to "assist countries in the preventing, recording, notification and, if applicable, offering compensation for diseases caused by work."[21] Similarly, the International Classification of Diseases (ICD) provides "an international diagnostic standard for health-related information, clinical records and statistical information collection ... [which] defines the group of diseases, disorders, injuries and other health conditions and organizes them in a hierarchical and comprehensive manner ..." in order to assist relevant bodies in identifying occupational diseases.[22] While the ICD does not specifically aim to identify occupational diseases, but rather to classify all diseases, it offers a section dedicated specifically to occupational issues and workplace exposure to risk factors. Therefore, instead of reinventing the wheel each time, such tools may be used to minimize the burden of proof for each individual worker.[23]

17 List of Occupational Diseases (revised 2010), p. 7
18 List of Occupational Diseases (revised 2010) , p. 7
19 List of Occupational Diseases (revised 2010) , p. 8
20 Occupational health and safety in Finland
21 List of Occupational Diseases (revised 2010), p. V
22 International Statistical Classification of Diseases and Related Health Problems (ICD)
23 List of Occupational Diseases (revised 2010), p. 9

The Data

Estimates and data documenting occupational diseases help determine the impact that they have on workers. In general, the data distinguishes between cases of fatalities, non-fatal/fatal cases, cases of accidents and injuries at work and cases of occupational diseases. It is estimated that more than 2.78 million workers a year worldwide die as a result of work-related injuries and illnesses.[24] The vast majority of these cases (86%) are occupational diseases.[25] In other words, every day there are about 7,500 work-related deaths worldwide, of which about 6,500 are the result of work-related illnesses. The ILO estimates that there are between 313 and 340 million non-fatal injuries each year,[26] while only about half as many (160 million) cases a year of workers that contracted non-fatal occupational disease.[27]

While this data may offer some sense of the impact of occupational diseases, the picture that emerges is probably incomplete. In the opinion of most occupational safety and health bodies, cases concerning safety and health at work, especially occupational diseases, are not properly reported in many countries, and therefore the actual number of fatal and non-fatal occupational injuries among workers is not apparent. The ILO has warned on several occasions that occupational diseases and injuries go unreported and that the data is incomplete.[28] In one of their 2020 reports, the ILO went so far as to say that "worldwide reporting and data collection on deaths, injuries and illnesses and their analysis, do not provide an accurate picture regarding the extent of occupational safety and health challenges."[29] Other international bodies echo these warnings as well.

Local bodies face similar challenges in trying to estimate and document the extent of occupational diseases. The U.S. Bureau of Occupational Statistics warns that "the data often does not take into account [non-fatal] occupational diseases."[30] Similarly, the Occupational Diseases Registry in Israel recognizes that "in Israel, as in other countries, occupational diseases are not given sufficient importance. The available information indicates that occupational diseases are a global problem that causes significant financial costs for the country."[31] Accordingly, a report by the Knesset Research and Information Center dated June 20, 2021 mentions that "the Health Ministry says that the reporting of [occupation diseases] cases following exposure in the workplace is insufficient."[32] In addition, as the Israeli Safety

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24 Vision Zero Fund, ILO

25 International Labour Standards on Occupational Safety and Health, ILO

26 Vision Zero Fund, ILO; Quick Guide on Sources and Uses of Statistics on Occupational Safety and Health, ILO

27 World Statistics, ILO website; Vision Zero Fund, ILO

28 Quick Guide on Sources and Uses of Statistics on Occupational Safety and Health, ILO, p. 32; Safety + Health for All, an ILO flagship program, key facts and figures (2016-2020), p. 15

29 Safety + Health for All, an ILO flagship program, key facts and figures (2016-2020)

30 The quest for meaningful and accurate occupational health and safety statistics, the US Bureau of Labor Statistics website

31 Israel's Health Ministry website

32 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 3

Administration reported to the Knesset Research and Information Center, “concerning the number of workers exposed to harmful chemical agents exceeding the permitted levels, the Administration does not have such information”.[33]

There are a variety of reasons for the incomplete recording and under-reporting of occupational diseases, including a lack of dedicated resources for the task, gaps in medical knowledge, and focusing on one group of workers at the expense of another (e.g.., citizens versus migrants, large workplaces versus small ones, or construction/agriculture/manufacturing workers versus other sectors). In addition, the need to prove a causal link between a certain illness and exposure in the workplace can be challenging, when the disease is caused by occupational risk factors, that the worker may have (e.g. smoking and exposure to asbestos, both are recognized as causes for lung cancer). As the Bureau of Occupational Statistics states, their data “often does not refer to occupational [non-fatal] diseases because workers whose diseases may have long incubation periods often retire or change employers or change their place of living before the disease is diagnosed. Moreover, it is often difficult to attribute a medical condition directly to the exposure in the workplace.”[34] Similar conclusions were made by the Knesset Research and Information Center, which found that although there is a regulatory obligation to conduct environmental-occupational assessments, to collect information on occupational safety focusing on prevention in Israel and to anticipate and control risk factors for exposure in the workplace, in fact such information does not exist. “The Administration’s website contains reports on monitoring and enforcement that hardly ever deal with occupational health, but focus instead on enforcement activities regarding safety violations on construction sites.”[35] Part of the challenge in enforcing the mandate to anticipate and prevent exposure to risk factors arises due to the lack of appropriate training programs for supervisors. As a result, there are few individuals qualified to perform assessments and maintain databases detailing risk factors.[36]

Therefore , institutions that collect data on occupational health and safety, such as in the United States and Israel, flatly refuse to collect or publish data on fatalities caused by workplace diseases. The U.S. Bureau of Occupational Statistics defends its decision not to include any statistics on deaths caused by occupational diseases in its reports, arguing that “data [almost] cannot be collected with a reasonable degree of accuracy” and therefore “data on fatal occupational diseases cannot be published.”[37] Nevertheless, the U.S. Bureau

33 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 9

34 The quest for meaningful and accurate occupational health and safety statistics, the US Bureau of Labor Statistics website

35 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 18

36 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 19

37 The quest for meaningful and accurate occupational health and safety statistics, the US Bureau of Labor Statistics website

of Occupational Statistics admits that deaths caused by occupational diseases make up the vast majority of fatalities in the workplace, just as external researchers have estimated that “there were nine times more cases of fatal illnesses than fatal injuries in the workplace.”[38] The Israeli Occupational Health and Safety Administration estimates that about 800 workers die from occupational diseases or complications thereof every year in Israel; however, this is likely an underestimation and a breakdown of the number of deaths by disease is not made public.[39]

The reservations described above regarding the extent of occupational health problems, especially regarding occupational diseases, naturally cast a shadow of doubt on available data, primarily because many countries fail to track death cases caused by occupational diseases. Given the international statistics indicating that occupational diseases account for 86% of all fatalities in the workplace, it is likely that countries are not documenting the full extent of workplace deaths. Similarly, some documented Israeli numbers of non-fatal cases vary greatly from international statistics, which estimate that non-fatal diseases in the workplace account for about half of all non-fatal workplace injuries. In Israel between 2011 and 2017, the state recorded an average of 67,115 cases of non-fatal occupational accidents per year.[40] Therefore according to the ILO, the number of casualties from non-fatal diseases per year in Israel should thus be about 35,000. This number is aligned with ILO’s estimates that there are tens of thousands of cases due to occupational morbidity in Israel. However, the last report published by the Occupational Diseases Registrarin 2019, indicates there were only 1,727 cases of occupational diseases reported by occupational physicians. Furthermore, there were 1,876 additional cases that were recorded by the National Insurance Institute.[41]

38 The quest for meaningful and accurate occupational health and safety statistics, the US Bureau of Labor Statistics website

39 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 4

40 Adam Committee report, p. 21

41 Occupational Diseases in Israel, update for 2017 data, the National Center for Disease Control, Ministry of Health, p. 3

Chapter 2

International Commitments – ILO

Before describing the government bodies dealing with occupational health and safety in Israel, it is important to recognize the role of international institutions. The leading international labor body, the ILO, influences Israeli occupational health and safety practice. The ILO has assisted in defining occupational diseases, promoting awareness and establishing various frameworks in the field. Specifically, the ILO has established international labor standards through conventions, protocols and recommendations, and, in addition, offered countries guidelines for the implementation of the various conventions. As mentioned, the ILO has 19 legislative publications relating to safety and health at work - 8 conventions and 11 recommendations. Of these, Israel has ratified only the Benzene convention. Since the recommendations are voluntary, the ILO does not track the recommendations adopted by member states.[42]

The ILO's policy on occupational safety and health is set out in three main conventions along with their associated recommendations. The first major legislation item, the Framework Convention for the Advancement of Safety and Health at Work (Convention No. 187) and its recommendations (Recommendation No. 197), establish a permanent process for ongoing improvement of safety and health at work and fostering a culture of prevention regarding violations of safety and health rights. The second legislation item, the Convention on Occupational Safety and Health (Convention No. 155) and its recommendations (Recommendation No. 164), obligate member states to adopt and implement occupational safety and health policies. In addition, there is another protocol from 2002, which calls for "establishing requirements and procedures for registering and reporting accidents and occupational diseases, to carry out their periodic inspection and to publish annual statistics."[43] In 2002, the International Labor Organization also formulated recommendations regarding a list of occupational diseases and a mandate to register and document accidents and illnesses in the workplace (Recommendation No. 194), which was then updated in 2010.[44] The third critical legislation item is the Occupational Health Services Convention (Convention No. 161) and its accompanying recommendations (Recommendation No. 171), which stipulate that member states must establish occupational health services that include occupational health monitoring and contribute to the implementation of occupational health and safety policies.

42 FUNDAMENTAL PRINCIPLES OF OCCUPATIONAL HEALTH AND SAFETY , Benjamin O. Alli, p. 9; ILO website
43 FUNDAMENTAL PRINCIPLES OF OCCUPATIONAL HEALTH AND SAFETY , Benjamin O. Alli, p. 11-12.
44 Recommendation no. 194, ILO; Updated list of occupational diseases, 2010, p. 4

Occupational Health and Safety Administration

The main regulatory body in Israel in charge of preventing occupational accidents and protecting workers' health is the Occupational Health and Safety Administration. Until recently, the Administration was part of the Labor Department of the Ministry of Labor, Welfare and Social Services. During the 24th Knesset (2021), the Labor Department as a whole was transferred to the Ministry of Economy, and so the Administration is now under this ministry. The authority of the Administration derives from the Labor Inspection (Organization) Law, 5714-1954 and from the Work Safety Ordinance (New Version), 5730-1970. The Administration's activities mainly include workplace inspections, enforcement of safety and health standards, setting conditions and standards for appointing office holders, setting conditions and requirements for granting licensing for certain workplaces and promoting safety in the workplace. The Administration is responsible for the certification and licensing process and is also in charge of occupational hygiene through funding various initiatives and research projects that promote safety in the workplace.[45] In addition, the Administration also collects reports from various sources about safety hazards and workplace injuries or illnesses and transmits them to other relevant bodies addressing occupational safety and health.

Pursuant to Section 3 of the Accidents and Occupational Diseases (Notification) Ordinance (1945), an employer must immediately report any workplace injury resulting in a worker being unable to work for more than three days or in a worker's death. According to Section 5 of the Ordinance, any qualified physician who is of the opinion that a patient they are treating has contracted an occupational disease, must report this in writing to the Administration. In addition, the general public may report hazards in the workplace. The Administration collects all such reports, documents them and sends them to other occupational safety and health bodies, such as the Registrar of Occupational Diseases.

The Occupational Health and Safety Administration is also responsible for the appointment of foremen, safety officers and safety committees, in compliance with the various standards and training requirements established by the Administration. In addition, the Administration grants licenses to certain businesses under the Licensing of Businesses Law, 5728-1968, which ensures that these companies operate in accordance with safety and health standards.

Most importantly, the Occupational Health and Safety Administration serves as a supervisory and enforcement body in Israel on matters relating to occupational health and safety. The Administration is charged with sending inspectors to workplaces to assess work conditions and identify possible risks through unannounced visits or, alternatively, following mandatory

45 Occupational Health and Safety Administration, website

reports submitted by workplaces. While inspectors have the authority to close workplaces based on concerning findings, closing a workplace is rare in reality. Instead, inspectors are more likely to issue "improvement orders" requiring workplaces to comply with the safety and health requirements noted within two weeks of the order's issue date. In addition, the Administration has the authority to issue safety orders that require immediate rectification of risks and hazards in the workplace, after which inspectors may appoint foremen and safety inspectors, as well as fine workplaces that do not meet the requirements of "improvement orders." In more severe circumstances, such as in the case of a life-threatening injury or death of a worker, inspectors may order cessation of work at the site until the hazard is removed. If the severe injury or death occurred on a construction site, inspectors may stop work for at least 48 hours.

Under the Penal Code, the Occupational Health and Safety Administration can enlist the help of the police to enforce safety orders, initiate criminal proceedings and impose fines against employers who have violated safety or improvement orders. The Occupational Health and Safety Administration also has an investigation department that examines violations of safety regulations in the workplace. The department strives to prevent the recurrence of workplace accidents and occupational diseases by prosecuting those who violate workplace safety laws. The Administration also has the administrative authority under the 2017 Enhanced Enforcement of Labor Laws, 5772-2011, to impose financial sanctions between NIS 20,220 and NIS 35,380 on employers. This sanction is used mainly against building contractors that violate safety regulations on construction sites.

Despite the central role of enforcement mechanisms for any regulatory body, the Administration's oversight efforts are greatly hampered by limited resources. The Occupational Health Administration employs only about 100 inspectors throughout the country.[46] These inspectors are supposed to have expertise in and be familiar with the hazards and risks that pose a threat to the health and safety of workers in all sectors. As a result of limited resources and capabilities, however, occupational safety regulations are more widely enforced than occupational health, since inspectors lack the specialized training needed to identify occupational diseases.[47] With regards to occupational health, the Administration focuses mainly on monitoring hazardous materials and initiates activities mainly in the manufacturing, construction and agriculture sectors. Based on data submitted to the Knesset Research and Information Center, there has been a decrease in the number of monitoring activities carried out by the Administration in recent years, as inspectors have been reassigned to perform enforcement activities in the construction sector, among other things.[48] This will be described in more detail in Chapter III.

46 Adam Committee report, p. 90

47 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 19

48 Aspects of protecting workers exposed to chemicals in the workplace, the Knesset Research and Information Center, p. 10

Registrar of Occupational Diseases

The Registrar of Occupational Diseases, formed in July 2011, is tasked with collecting specific data regarding occupational diseases under the auspices of Ministry of Health's National Center for Disease Control. It is funded by the Occupational Health and Safety Administration within the Ministry of Economy and is responsible for collecting up-to-date, reliable and readily available information regarding occupational diseases. [49]The Registrar is professionally guided by a steering committee consisting of representatives of the Ministry of Economy, the Ministry of Health, the National Insurance Institute and representatives of the departments of occupational medicine associated with the various HMOs. In terms of legal authority, the Registrar of Occupational Diseases was created under the Accidents and Occupational Diseases (Notification) Ordinance (1945) and the Occupational Diseases (Notification - Additional List) Regulations (1980).

The Registrar's main task is to monitor trends and patterns in occupational diseases, including the emergence of new diseases. The registrar is required to identify high morbidity levels and locations of increased risk.[50] Since July 2015, the Registrar has published five reports utilizing occupational diseases statistics from the Administration and the National Insurance Institute. The Administration collects data from reports submitted by occupational physicians and the Registrar organizes the information by disease, sector, type of work, reporting body, geographic location, worker age, nationality and gender. The Registrar encounters difficulties in its attempts to expand the reporting efforts and in obtaining information on morbidity which is suspected to occur for occupational reasons as per various sources (the National Insurance Institute, the Tax Authority, the insurance companies, etc.). Ultimately, having good information is necessary for strategic planning and addressing issues relating to occupational diseases.

The Israeli Institute for Occupational Safety and Hygiene

The Israeli Institute for Occupational Safety and Health (IIOSH) is a non-profit statutory body established in 1954 under the Labor Inspection (Organization) Law, 5714-1954. It is funded by the Social Insurance Institute in Israel[51] and promotes "a culture of

49 Ministry of Health, Occupational Diseases Registrar
50 Ministry of Health, Occupational Diseases Registrar
51 Adam Committee report, p. 43; 66c, 2016, p. 2012.

occupational safety and health."[52] It does not serve as regulatory body and so does not deal with enforcement or inspection. Instead, the Institute focuses solely on prevention and research. The Institute initiates educational and training programs and serves as an advisory body to the Minister of Economy with a focus on efforts to promote and raise awareness of occupational safety and health. For example, the Institute recently launched "Line to Life," a website that enables the public to report imminent risks at construction sites.[53]

The Institute offers training courses, usually free of charge, for various sectors on a range of topics related to work and publishes materials in Hebrew and occasionally in other languages such as English, Arabic, and Russian. In addition, the Institute offers educational resources, online events and guides on occupational safety and health, focusing on prevention, conduct surveys of workplaces regarding occupational hazards and risks. In order to reach diverse audiences, many training sessions are held through the Institute's mobile units that travel to workplaces at no cost.

As part of prevention efforts, the Institute also conducts research so as to provide relevant information for various work sectors. As such, the Institute participates in and shares research that explores the effects of certain substances and activities on workers. The Institute also identifies risk factors across various sectors and provides guidelines on measures that should be adopted to prevent diseases and injuries in the workplace. For example, in 2019, the Institute published a report on occupational skin exposure among beauty salon workers.[54] The Institute also recently researched ergonomic risk factors in the agricultural sector and issued recommendations for reducing and preventing musculoskeletal injury.[55] These efforts are part of the Institute's overall work to educate workers and employers about hazards in the workplace through the publication of informational materials covering specific risk factors in more than 400 professions.[56] In addition to information regarding hazards and risks in certain sectors, the Institute also raises awareness about specific occupational safety and health issues. For example, one of the Institute's main activities is educating employers on the occupational safety and health needs of people with disabilities. The Institute also recently published a report on challenges facing workers with disabilities during the Covid-19 pandemic.[57]

52 Israel Institute for Occupational Safety and Hygiene website
53 Line to Life, Israel Institute for Occupational Safety and Hygiene
54 occupational cutaneous exposure among hairdressers in hair salons and beauty salons, Dr. Asher Pardo, Nitzan Reyes-Havelin, Rana Dalsha, Research Department, the Institute for Safety and Hygiene
55 Ergonomic Risk Factors in Agriculture, Avital Radosher, National Ergonomics Instructor, Institute for Safety and Hygiene
56 Employment Risk Information Database, occupational safety and health administration unit
57 Occupational Difficulties of People with Disabilities during Corona, Livnat Cohen, the Institute for Safety and Hygiene

Occupational Physicians and Occupational Medicine

As stipulated in the Work Safety Ordinance (New Version), 5730-1970, and in the National Health Insurance Law, 1994, occupational physicians play a crucial role in advancing occupational safety and health. Occupational physicians, sometimes referred to as occupational health expert physicians, are "general practitioners who have completed an internship period in occupational medicine and health and are certified to work in this field."[58] The role of Occupational physicians, is primarily to diagnose and treat occupational diseases and work-related injuries, as well as perform fitness-for-work physical examinations.[59]

Occupational medicine services are provided by virtue of the National Health Insurance Law. Israeli workers encounter occupational physicians in one of three types of examinations:[60]

- Job acceptance tests to determine the suitability of an employee for a specific occupation before entering the workplace.
- Routine medical examinations performed by law for groups of workers who are said to be exposed to certain risk factors in order to determine their fitness for continuing such work.
- Fitness-to-work physical examinations to determine a worker's ability to continue their job after they have fallen ill or have been injured. This is the most common examination.

Pursuant to section 5(1) of the Accidents and Occupational Diseases (Notification) Ordinance (1945), any physician may diagnose an occupational disease and it is his/her responsibility to report the diagnosis to relevant government bodies. Virtually all (99.4%) of occupational diseases cases in Israel are reported by occupational physicians.[61] This number is particularly striking given that there are only 90 occupational physicians[62] for more than 4.1 million workers in Israel[63] based on data from the Ministry of Health from at the beginning of 2021.[64] It is worrying that such a small number of physicians diagnose 99.4% of all occupational diseases—many cases likely go unreported as workers may not have access to an occupational physician.

58 Who is an Occupational Physician, International Hazard Datasheets on Occupation
59 Occupational Health Physician, definition
60 Occupational Medicine, the Ministry of Labor, Welfare and Social Services
61 Occupational Diseases in Israel, update for 2017 data, the National Center for Disease Control, Ministry of Health, p. 8
62 Davar Magazine, May 2020
63 Bank of Israel Data, July 2021
64 The Number of Physicians in Israel: Trends and Policy Suggestions, February 2021, Health Ministry

The National Insurance Institute

The National Insurance Institute in Israel also plays a role in occupational safety and health issues. Most of the budget of the Israeli Institute for Occupational Safety and Hygiene is funded by the National Insurance Institute, which also funds activities to promote occupational safety and hygiene.[65] For example, the National Insurance Institute imparts knowledge to workers employed in small- and medium-sized workplaces regarding the importance of a healthy lifestyle, ergonomics, and healthy nutrition in order to improve worker awareness of occupational safety.

The involvement of the National Insurance Institute in occupational health and health stems from its role as a regulatory body authorized to compensate workers for occupational diseases.[66] A person injured on the job who is no longer able to work in their position or another similar one as result of the injury can file a claim for injury benefits.[67] According to National Insurance Institute data, about 67,000 workers a year receive injury benefits for work accidents.[68] However, despite the wide-ranging role of the NII on paper, as the State Comptroller's report shows, the transfer of information between the National Insurance Institute and the Registrar of Occupational Diseases is deficient, especially regarding the type of diseases, the number of claims and statistical information regarding workers and sectors.[69]

National Council for Worker Health

The National Council for Employee Health advises the Ministry of Economy and the Ministry of Health and strives to: reduce the number of patients with occupational diseases, increase physician awareness of occupational diseases, advance legislation, improve enforcement in the workplace and more. The council organizes seminars and professional conferences, develops models and writes position papers intended for decision-makers. For example, in June 2019 the council recommended that physicians be required to note a patient's occupation in their medical record.[70] In May 2020 the council also recommended clarifying the role of a Safety Assurance Officer that would assume responsibility for occupational health to prevent morbidity among workers, based on recommendations also previously made by the Adam Committee report (this role currently exist, but the professional requirements are not clear).[71]

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65 Call for Proposals: plans to advance occupational health, the National Insurance Institute
66 The State Comptroller Report, p. 1051
67 Call for Proposals: plans to advance occupational health, the National Insurance Institute
68 Adam Committee report, p. 21
69 The State Comptroller Report, p. 1051
70 Recommendations to introduce occupation list in medical records, June 2019, Ministry of Health
71 Adam Committee report, p. 85; Recognition of the role of Hygiene Officer, position paper, May 2020

Chapter 3

Critical Analysis

Two major reports published between 2014 and 2016 laid the foundation for critical thinking in the field of occupational health and safety in Israel. The first was a 2014 report by the Adam Committee, a body established by the former Minister of Welfare and Social Services, Shalom Simhon, to advance occupational health and safety in Israel. From February to October 2015, the State Comptroller reviewed various aspects of worker safety and health, including implementation of reforms suggested by the Adam Committee regarding several governmental authorities: the Occupational Health and Safety Administration, the Israeli Institute for Occupational Safety and Health, the Ministry of Health and the National Insurance Institute. The State Comptroller's report concluded that most of the recommendations made by the Adam Committee had in fact not been implemented. Unfortunately, there has been no change, not even concerning occupational health, since the State Comptroller published this report in 2015.

An initial reading of the two reports reveals a clear difference in attitude toward occupational safety compared to occupational health. The reports dedicate much less space and analysis to occupational health compared to occupational safety, even though figures from international research clearly show that mortality rate due to occupational diseases is higher than that of work accidents. In general, in Israel there is much less focus and critical thinking on occupational health, leading to poor investment in research.

“There is currently no nationwide ‘occupational health map’ in Israel. ”[72] reads the report of the Adam Committee. “This means there is no good information on the size of the groups of workers exposed to the various occupational risk factors (as defined in the regulations). This situation does not allow for proper preparation for inspections or clarifying the needed coverage for inspections at present let alone for future planning.” This statement aptly describes the state of affairs of occupational health in Israel.

The main recommendations of the Adam Committee report centered around establishing a national body for the management of occupational safety and health that could both serve as a regulator and provide professional guidance. They suggested that this body also include a research and information center to manage existing knowledge on occupational health and safety. In addition, the Committee suggested that current occupational safety and occupational health legislation be reformulated and combined into a single law. The combined law should include multiple tiers, including primary legislation, secondary legislation, professional codes, recommendations, guidelines and standards.

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72 Adam Committee report, p. 64

The Adam Committee addressed a number of areas relating to occupational health, but identified three main fields: occupational medicine, occupational hygiene as well as knowledge and research. Occupational medicine is a branch of medicine that deals with assessing risk factors in the workplace, identifying occupational exposure of a specific worker or group of workers to risk factors, as well as identifying and preventing occupational diseases due to exposure to various factors. The second tier deals with occupational hygiene, which is designed to assess and control health risks in the workplace and propose solutions. In both of these areas the deficiencies are sizeable.

Chronic Shortage of Skilled Manpower

The number of occupational physicians is small and continues to decline – resources designated to occupational medicine are alarmingly meager. When the Adam Committee report was written in 2014, the number of active occupational physicians in Israel was about 100-120.[73] According to official reports, in 2020 there were about only 90 occupational physicians,[74] and, according to experts, **there are only 75 active occupational physicians as of 2021** - and their number continues to shrink. The Adam Committee report findings indicate a ratio of one physician to 33,000 workers in Israel, whereas in Europe the ratio is 1:1,550-4,500 and in the United States it is 1:13,000.[75] The report shows that ratios found in Europe and the US are made possible by engaging general practitioners or other expert physicians as occupational physicians, which is not possible in Israel due to a general shortage of physicians, including emergency physicians. The Adam Committee recommended reorganizing all occupational medicine services, finding ways to make them more accessible to workplaces and launching specialized training programs to address the shortage of skilled occupational physicians.

Occupational hygiene is not considered a profession - the Adam Committee report defines occupational hygiene as “a science and profession that deals with the identification, recognition, assessment and monitoring of workplace risk factors. ...”[76] Currently, occupational inspectors are employed by the Occupational Health and Safety Administration, which has limited knowledge of occupational hygiene. Unfortunately, the profession of occupational hygiene officer is not well defined in Israel and the report made it clear that it is necessary to establish such a profession, set academic requirements for training programs in the field and formulate standards for assessing potential risks to occupational hygiene.[77]

73 Adam Committee report, p. 9
74 Davar Magazine, May 2020
75 Adam Committee report, p. 9
76 Adam Committee report, p. 83
77 Adam Committee report, p. 85

Shortage of information and data – both the ILO and the Adam Committee reports point to a shortage of data and information about occupational health due to gaps in several areas: (1) availability of data; (2) type of information that can be collected in an optimal system; and (3) collaboration between the various bodies engaged in the field and the integration of data, which is so critical for applied research.

The occupational health information available at present relies on data stored in current databases (in the following discussion we refer to the Registrar of Occupational Diseases, which is entrusted with collecting information), which is rather limited and covers a very narrow segment of workers and workplaces. In addition, workers' medical care is distributed among various health funds, which makes the task of collecting and analyzing information on their treatment difficult and less than optimal. Ultimately, the shortage of aggregate data prohibits drawing virtually any conclusions about the exposure of workers to environmental risk factors at work.

The quality of available information could be improved in various ways. For example, the simple step of having occupational physicians note the occupation of their patients in medical records would allow for wider data collection that could ultimately help to link occupation types to diseases. As we learned during the coronavirus pandemic, the Israeli health system is very capable of collecting data when it makes this a goal.

In addition to the issues noted above, there is also insufficient applied research on occupational health. The Israeli Institute for Occupational Safety and Hygiene publishes many studies in Hebrew, but they are predominately translations of published research conducted in various places around the world rather than in Israel. The Institute does not conduct applied research in collaboration with the Occupational Health and Safety Administration (responsible for regulation) or with other stakeholders. As noted at the beginning of this report, a better understanding of occupational diseases worldwide is emerging thanks to the work of international institutions who are conducting applied research among groups of workers and workplaces. Applied studies such as these in Israel could provide a valuable foundation for improving the effectiveness of enforcement actions and optimizing the prevention of occupational diseases.

The Registrar, as described in the previous chapter, is responsible for collecting data on occupational disease. However, an analysis of the Registrar's reports highlights the problematic nature of data available at present regarding occupational diseases as many groups of workers are under-represented due to the absence of legislation requiring gathering of information on such groups and the resulting lack of information regarding employers and workers.

Limited number of reports regarding cases of occupational diseases - the Registrar

primarily obtains its data from occupational physicians. Given the severe shortage of occupational physicians, however, it is estimated that the number of cases reported is much lower than the number of workers who contracted occupational diseases. The last report on occupational diseases, published in 2019, covered the year 2017 and identified 2,085 reported cases in which workers were suspected of having contracted occupational diseases—1,737 of these were confirmed eventually. Of the confirmed cases, 1,727 (99.4%) were reported by occupational physicians.[78] An additional 1,876 cases of confirmed occupational diseases were reported by the National Insurance Institute.[79] In total, the report claims, 3,613 cases of occupational diseases were identified in 2017.

According to a report by the Adam Committee, ILO estimates indicate that hundreds of people die in Israel each year from diseases due to their dangerous work environment. The report mentions another figure that relies on a mathematical model that compares Israel to other countries with similar attributes. The model that provides more accurate data, indicates that 1,700 people die each year from occupational diseases in Israel. However, even the Adam Committee believes that this figure is an under estimation, given the lack of accurate data worldwide. The Adam Committee report further notes that in relation to non-fatal diseases, the ILO estimates that there are tens of thousands of workers who contracted occupational diseases in Israel. Another comparative source that shows that the official number is lower than the actual number of workers whose health is compromised at work, is the one mentioned in the first part of the report, which compares the number of non-fatal occupational diseases. From 2011 to 2017, the state recorded an average of 67,115 cases of non-fatal occupational accidents per year, and ostensibly, according to the ILO, the number of casualties from non-fatal diseases per year should be about half that number, i.e. about 35,000 occupational diseases. In fact, based on the report of the National Center for Disease Control, as of 2017 as stated, only 1,737 cases of occupational diseases that meet the center's criteria, were recorded.

Under-representation of women and many other groups of workers - data analysis in the Registrar's report reveals that many groups of workers are under-represented. The data in the last report for 2017 (published in 2019) shows that 8.9 Jewish workers were injured per 10,000 Jewish workers, compared to 11.1 injured per 10,000 Arab workers.[80] Among men, the ratio is 14 injured workers per 10,000, compared with 4.3 injured women workers per 10,000, which indicates a significant under-representation. The data is calculated based on reports submitted by occupational physicians and data provided by the National Insurance Institute.

In addition, the data obtained only from occupational physicians shows that 55% of the cases

78 Registrar report 2017, p. 8
79 Registrar report 2017, p. 4
80 Registrar report 2017, p. 23

relate to workers in construction and the manufacturing sectors,[81] and about 66% of cases relate to establishments with 50 or more workers.[82]

A possible explanation for this data, and for the under-representation of certain groups, arise, among other things, from the legislative structure that protects workers in large workplaces, with a larger number of workers, while imposing requirements on the employer that maintain their health, including the appointment of safety officers and safety committees in plants with 50 and 25 workers respectively. The under-representation of women may be explained by the fact that women work in industries in which there is less exposure to hazardous substances, or alternatively by the lack of response to occupational diseases that women are exposed to in their occupations. The topic of under-representation will be further discussed in following chapters.

Missing legislation and regulations - despite constant changes in the labor market, labor legislation is lagging behind. Consequently, many professions remain off the map of occupational health. The Adam Committee's report notes that "despite the knowledge we have about additional risks that workplaces face, since 1994 (when the National Health Insurance Law was introduced) there was no new regulation that requires performing medical inspection tests (the basic basket of occupational medicine services), because the expansion of occupational medicine services basket is not possible without allocating financial resources to this end."[83]

Existing legislation includes a number of items that regulate the regulator's enforcement authorities in the workplace, the provision of health services to employees, and a list of diseases and their associated harmful exposures,[84] which require periodic or preliminary inspections or enforcement. Therefore, the situation as defined by the Chairman of the Occupational Physicians Association, Dr. Raz Dekel, is that the regulations currently identify 22 harmful exposures of workers to chemical substances or physical exposures such as noise. According to Dr. Dekel, the regulations are obsolete, and most of them refer to very small groups of workers. However, since these risk factors are known, they are being addressed while other causes of occupational diseases, are left unregulated.

Moreover, pursuant to the Labor Inspection (Organization) Law, (1954) and its derived regulations, establishments with more than 25 employees are likely to have safety committees, that were established with the help of the IIOSH, and establishments employing more than 50 workers, to which the Occupational Safety Ordinance applies, there will even be a Safety Officer. This means that in these workplaces, especially those with a Safety Officer,

81 Registrar report 2017, p. 13
82 Registrar report 2017, p. 13
83 Adam Committee report, p. 62
84 Occupational diseases (Notification - Additional List) regulations, 1980

there should be a more professional response to safeguarding the safety and health of their workers. It should be noted that the State Comptroller's report of 2016 pointed at the flawed establishment of safety committees.

The outdated regulations, which are no longer applicable to all workers, along with guidelines that limit the appointment of safety committees or safety officers to certain workplaces highlight the biased data in the reports of the Occupational Diseases Registry. Most of the cases are reported by large establishments, the sectors represented in the registry are those defined by the law, and it is safe to assume that the occupations recorded are predominantly those held by men. Consequently, many occupations and small workplaces as well as women workers are under-represented, and not sufficiently inspected and supervised.

In other countries there is a growing awareness of many risk factors, which currently receive no attention in the occupational health map in Israel: issues of ergonomics, stress and abuse at work are the focus of global professional discourse, and yet are completely absent from the Israeli occupational health map. Moreover, workers of older ages, workers with disabilities and other worker groups are not addressed.

Action must be taken to increase awareness of various types of occupational diseases and to act from a holistic perspective on several levels at once in order to correct the existing situation. Actions may include: formulating relevant regulations that address other risk factors, such as mental health factors; increasing the number of occupational health professionals and train them; raising awareness among General Practitioners; training additional supervisors who could be responsible for examining deficiencies and taking preventive measures regarding occupational diseases; and setting clear and precise goals for law enforcement.

As long as the most basic recommendation of the Adam Committee report—to create an "occupational health map"—has not been implemented nor any national regulatory body established to assume the powers currently held by various government ministries, that do not include sufficient number of health professionals, such a holistic view will not be possible and no real change will take place. However, it seems that the establishment of such a body is not a priority for decision-makers, nor was it before the coronavirus pandemic.

Conclusion

The current state of affairs regarding the handling of occupational health by the various authorities is dismal. The number of cases in under-estimated and morbidity factors that characterize the modern employment market go unexamined. Many groups of workers, including marginalized, ununionized and "invisible" workers, remain under the radar, and occupational health regulations are not enforced even when it comes to professions that are supposed to be closely monitored. The authorities allocate insufficient resources for research and monitoring and the recommendations submitted by the Adam Committee and the State Comptroller have been rendered meaningless when it comes to occupational health. Moreover, even the recommendation to establish a new official profession to monitor and enforce occupational health regulations has not been implemented. Obviously, the occupational health of workers is not a top priority for the authorities.

This situation highlights the need to be more precise in defining what steps need to be taken to improve the implementation of occupational health—particularly those that should be higher up on the public agenda and not included in the same category as "occupational safety." The recommendations for needed reform were submitted to policy makers years ago, and have yet to be adopted in order to address the problematic situation of occupational health and promote change in this field in Israel.

Change is essential—first and foremost for marginalized populations of workers. Kav LaOved supports particularly vulnerable workers who do not have adequate work conditions, whose right to health, just like their other rights, are violated. Yet, there is no good information about them, nor any systematic, applied research or enforcement system to protect them. Based on ILO reports, the populations most vulnerable to occupational diseases are those about whom information is often not collected. Effective enforcement for those who really need it should be based on data and knowledge and therefore the knowledge base must be expanded and the number of health professionals should increase and ensure that workers (including workers living in the economic and geographic periphery) know that this service is available to them. Moreover, applied research should be promoted. Methods of collecting data on diseases that afflict these populations should be improved in order to establish a causal link between diseases and the occupations held by these populations. Improving the knowledge base is a task that should be undertaken by the state authorities, for example, by engaging physicians at HMOs to help with establishing this causal link. Such actions will allow to calculate the distribution of occupational diseases among workers by levels of exposures and by profession.

Updated knowledge will make it possible not only to improve enforcement, but also to update regulations and legislation to suit the modern labor market. The voices of vulnerable workers should be heard through an initiative that documents their reality and their employment

conditions as they see them in order to enable the authorities to assist them. This initiave should be a collaboration between government, civil society, academia and other research bodies. We hope that this preliminary document will be a first step in promoting the occupational health of the workers, while connecting with them and making their voices heard.

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