Ministry of Social Affairs and Employment

Developments in the field of work and health in the Netherlands in the period of 1990-2010

Recommendation Paper for the Network of WHO Focal Points for Workers' health

7 April 2010 - Amersfoort, the Netherlands

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Colophon

This paper is commissioned for the ministry of Social Affairs and Employment of the Netherlands by Paul Baart and Tamara Raaijmakers, partners of BaartRaaijmakers.

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Contents

Summary

In a nutshell

This paper provides an overview of the developments in work and health in the Netherlands over the past twenty years. The highlights are summarized below.

Traditionally risk-oriented

Prior to 1989, the focus on work and health was at first risk-oriented: to prevent death, injury and ill-health due to unsafe working conditions. The Working Conditions Act derived from the EU Directive 89/391 provided a legal basis for this approach. The Act sets out a framework with minimum requirements and standards of protection for the creation of safe and healthy working conditions. The decrease of (fatal) occupational accidents indicates that the Act has had an impact on safety and health.

Imbedding social security in OSH

Despite the progress outlined above, the number of people unable to work was a cause of concern and formed the background for a new social security system in the Netherlands from 1989. Using financial triggers and following absence, employers and employees are motivated to focus on employment and return to work at the first opportunity. However the focus was still driven by statute and on the reduction and prevention of risk: preventing work disability due to occupational factors and diminishing the costs on disability benefits for employers.

Soft laws for more tailor made responses

The soft law (constructions) covenants (Arbocovenants, 1999-2007) are a first step for a more tailor made approach in which companies[1] together with social partners take greater responsibility for safety and health. The objective is still the prevention of illness, with rates of absenteeism and disability as the main indicators of success.

New style managing work and health

The Arbo New Style is a practical follow up to the Soft Laws. The early steps saw the provision of a framework of requirements by government, with the methods of achieving these requirements being left to the companies themselves in close co-operation with employees' representatives. For companies an important delivery instrument is the Arbo Catalog, which is developed at sector, industry or company level.

Workability and employability as new perspectives

Currently a number of challenges exist across all levels of employment. At the macro level a diminishing working population results in the urgent need for employees to work longer. At the meso level companies battle in a competitive market and to survive must retain good people within

[1] For more varied reading, we use various terms for the description of organizations (including profit and non profit). Such as companies, employers, enterprises et cetera. These terms are interchangeably.

the workforce. As a way of addressing this challenge, many businesses are adopting more flexible employment contracts. At the micro (organizational level) these changes in the world of work are the main motivations for organizations to invest in the employability of their staff.

At this time of financial crises the trade unions are also focused on employability as a 'guarantee' for work, while retaining safe and healthy labor conditions and the promotion of employees' interests on salary and secondary working conditions as a priority.

The social security regulations strengthen the focus on employability by making staying (even partly) at work more financially attractive. The Dutch Ministry of Social Affairs and Employment stimulates organizations to take action on work ability by subsidizing the introduction of the workability index (WAI).

> *One of the experts indicated that the WAI is a status quo instrument, measuring the workability at the moment. For preventive or health promotion intentions, a combination of the results of the WAI and Human Resource instruments is desirable i.e. about the performance at work. It is also emphasized that the indicators of measurements should be related to the work and the primary process of the organizations. For example with personnel of emergency care, measuring if they can re-animate for 15 minutes instead of their VO2 max.*

Workplace Health Promotion

Initiatives with this kind of label date back more than twenty years. Originally created by the Dutch Centre for Workplace Health Promotion (1995-2003), workplace health promotion actions are now mostly organized by private companies. The need for workers with high levels of employability is leading to raised levels of interest in workplace health promotion (WHP) in an increasing number of companies. Yet, the potential is not fully reached with only about 1 in 4 companies having any sort of a health policy - most of which consist of some kind of health screening activity such as lifestyle checks. An integrated approach to health management is still the field of front runners, mostly larger organizations.

In summary, notable developments in occupational safety and health in the Netherlands include:

- Soft Law, Arbo Catalog and the fourth discipline of Work & Organizational professionals in the Working Conditions Act are unique Dutch initiatives;
- The recognition that workplace health addresses more than just the individual health of the employees and that the organization of work and the working environment are significant factors;
- That a more supportive tailor made approach combined with a frame work with requirements is showing promising results for employees, employers and society;

- Online tools such as the digital risk inventory (ww.rie.nl) and a digital portal of the Ministry of Social Affairs and Employment about OSH (www.arboportaal.nl) support this trend of tailoring approaches to company needs while at the same time placing higher levels of responsibility for action on employers and employees;
- That a priority for work and health is the maintenance of employability of the Netherlands workforce;
- That, the promising initiatives for workplace health policies are not yet fully reached;
- That addressing short and mid term challenges such as ageing and mental health are core to business management processes and work and health initiatives;
- There is a role of other parties outside the field of work and health, including health and health promotion in other policies (health in all policies).

The recommendations of this paper consist of advice for other European countries based on the experience in the Netherlands and will explore further desired developments in the field of work and health.

Recommendations

These recommendations are based on the knowledge and experiences of the experts involved in the development of this paper, combined with (trend) reports on the field of work and health in the Netherlands.

Lessons learnt

Following the Dutch experiences of the last twenty years the following lessons can be learnt:

- Decent work itself is the starting point
- Safeguard at all times safe and healthy working conditions
- Healthy organization focuses on business priorities:
    - innovation
    - competitiveness
    - continuation
    - quality of products and services
- The workers' needs, visions and involvement are essential
- Focus on the relationship between employer and employee
- Health management must contribute to work culture and business performance
- Create key performance indicators on health (besides sickness and disability)
- The total health continuum is a useful description for the different health goals in a company:
    - health care
    - sickness and disability prevention
    - health promotion
- The success combination:
    - a framework of legal requirements supplemented
    - tailor made approaches
    - enforcement and fines as control mechanisms for the legal requirements
- The power full combination: integration of OSH and social security

- Health policy can be stimulated by economic incentives
- Use incentives to create a common set of goals for all stakeholders (employers, employees, trade unions, employers' organizations, insurance companies, government, society)
- Combine long term outcomes with short term benefits
- Eliminate the possibility of externalizing costs as a result of poor working conditions (direct costs of poor working conditions for organizations)
- For further challenges focus on especially health and health management is needed:
    - prolonging working life
    - the increase of chronic diseases
    - mental health problems
- Provide organizations with practical instruments to consolidate actions and policy
- Create new public-private alliances
- Introduce the work and health system in other policies and systems (such as professional guidelines of non OSH specialists)
- Trace unexpected players: local authorities, schools, communities, et cetera.

Comments on lessons learnt

Business perspective

The basis for health and safety at work are largely assured in the Netherlands. Besides this, the Netherlands is one of the EU countries with the highest educational level: almost 50% of those in work are highly skilled non-manual workers. Against this background, self-regulation and workers' participation make better sense. However, to reach the fully potential of self regulation and workers' participation, support is needed in terms of resources, especially time and expertise.. Besides the government, the trade unions and employers' organizations can be important players in this field.

Self employed people

Another trend is the growing amount of people working independently. More than 700,000 now work in this way in the Netherlands, a picture replicated in other EU countries. For these kind of workers there is no basic protection on work and health that is enshrined in law and the possibilities of making use of the social security system are minimal.

Work-private life

In line with the increase in self employed people and the trend of working at home, the line of separation between work and private life becomes unclear. This also highlights the need for a more

integrated approach towards health and work, besides the traditional occupational setting. Basically, the principles of health promotion are the same for occupational and public health promotion.

1 WHO Focal Points

This paper is commissioned for the Ministry of Social Affairs and Employment of the Netherlands. The Ministry participates in the Network of WHO Focal Points for Workers' Health. The WHO – World Health Organization- is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

Global Plan of Action on Workers' Health

One of the programs of WHO is concerned with the relationship between health and work, and this has resulted in a Global Plan of Action on Workers' Health (WHO, 2007). The need for this global plan comes from yearly figures on incidents and health related to work in Europe[2]:

- 27,000 deaths by accidents at work;
- 200,000 work-related illnesses (occupational diseases);
- 300,000 people permanently disabled;
- Or in economic terms: 5% loss of gross national product.

Linking occupational and public health

The aim of the global plan is to strengthen WHO action on occupational health and to link it to public health. Thus taking into consideration that workers' health is determined not only by occupational hazards, but also by social and individual factors and access to health services. Economic development is part of the plan emphasising that the health of workers is an essential prerequisite for productivity and economic development.

The move towards a global economy provides opportunities and risks for workers` health. The risks concern disadvantaged workers' groups such as 'informal' workers, those facing hazardous working conditions and underpaid jobs (also described as precarious work). Vulnerable groups are children, pregnant women, older persons and migrant workers. On the other hand, the increasing international movement of jobs, products and technologies can help to spread innovative solutions for the prevention of occupational hazards.

[2] The approximately figures are derived from the Presentation the Dutch ministery of Social Affairs and Employment, prepared for the WHO Focal Point second meeting at Struga Macedonia, September 2009

Objectives of the Global Plan

The objectives of the plan are (WHO, 2007):

1. to devise and implement policy instruments on workers' health;
2. to protect and promote health at the workplace;
3. to improve the performance of, and access to, occupational health services;
4. to provide and communicate evidence for action and practice;
5. to incorporate workers' health into other policies.

In summary, the background of these objectives is:

> '*All workers should be able to enjoy the highest attainable standard of physical and mental health and favourable working conditions. The workplace should not be detrimental to health and well-being. Primary prevention of occupational health hazards should be given priority. All components of health systems should be involved in an integrated response to the specific health needs of working populations. The workplace can also serve as a setting for delivery of other essential public-health interventions, and for health promotion. Activities related to workers' health should be planned, implemented and evaluated with a view to reducing inequalities in workers' health within and between countries. Workers and employers and their representatives should also participate in such activities'.*

Strengthening Health Systems

Translated to the European situation, the regional Goal of Improved Workers' Health in Europe can be stated as:

> '*To prevent work-related illness and injury and to promote workers' health and well-being through strengthening of health systems in the Member States of the Region'.*

Aim of this paper

This aim of this paper is to exchange information and experiences of the work and health system in the Netherlands and to encourage the strengthening of the systems on work and health at European level.

2 Outline of paper

The paper focuses on developments in the Netherlands over the past twenty or so years. It addresses the following areas of work and health:

1. Occupational Safety and Health (OSH);
2. Prevention;
3. Workplace Health Promotion (WHP).

For each of these three areas the paper provide insights in the available structures and systems. More specifically on:

- Intentions, aim and goal of the initiatives;
- Developments over time;
- The involved stakeholders;
- Results and effects: positive results and implications for improvement.

This is done at 'highlight' level, giving insight in to the Dutch milestones in this field during this period of time.

The paper also sets out a series of recommendations on work and health systems for counterparts in European Countries.

3 Methods

This report of developments in the field of occupational safety and health (OSH), (occupational disease) prevention and workplace health promotion in the Netherlands is based on available material and expertise in this field in the period January to March 2010. The materials were acquired in several ways including, desk research, web survey and by the direct involvement of experts.

3.1 Desk research and web survey

The materials provided by the Dutch Ministry of Social Affairs and Employment form the basis of the review. For example, material of initiatives in the Netherlands on behalf of the Ministry and related partners and material as a result of WHO focal point meetings.

We also used material such as articles and reports provided or referred to by the experts involved in the study, by network contacts and as a result of other (research) projects on these topics. Professional (management) magazines and conferences in the areas of work and health in the period December to March 2010 were used as additional sources of information. The final source of information was a survey of the websites of reputable organisations

3.2 Experts

Experts in the field of management, occupational health services, science of work and health, and working at a governmental level at the Ministries of Health and Social Affairs and Employment are involved in the development of this paper.

The experts commented on draft and adjusted versions, providing suggestions and comments on specific items in either a face to face or a telephone interview.

In Annex 1 the names and functions of the experts are listed.

4 Work and health

In line with the WHO Global Plan, the paper has a broad perspective on work and health. With a focus on: occupational Safety and Health (OSH), Prevention and Workplace Health Promotion (WHP).

4.1 Health Continuum

This focus can be seen as a 'health continuum'. Figure 1 gives an overview of this health continuum, together with the main characteristics of health care, prevention and WHP. In which 'health care' can be exchanged by OSH.

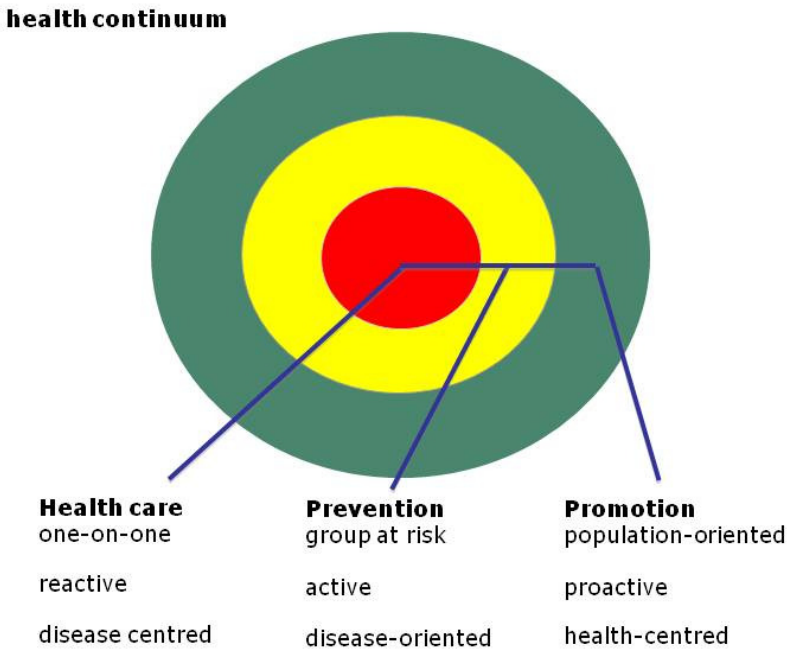


Figure 1: Health Continuum (Baart et al., 2003)

4.2 The Dutch work situation

The following data provide insight into the Dutch working life.

Dutch Population	Amount	Percentage
Total Dutch population (at 10 February 2010)	16,589,397	-
Dutch population: 15-65 years	10,969,000	66% of total population
Dutch working population: 15-65 years	7,317,000	44% of total population 67% of population 15-65 years

Source: Statistics Netherlands/CBS, figures of fourth quarter of 2009

Dutch enterprises	Amount	Percentage
Total enterprises (1 January 2008)	800,000	
Large enterprises > 250 employees	-	1% of total enterprises
SME's < 250 employees (2007)	786,000	99% of total enterprises
Small enterprises < 10 employees (2007)	-	50% of SME's

Source: Statistics Netherlands/CBS en www.mkbservicedesk.nl figures 2007

People working in	Amount	Percentage of total working population
Large enterprises > 250 employees	2.9 million	40%
SME's < 250 employees	4.4 million	60%

Source: www.mkbservicedesk.nl figures 2007

Kind of work in percentages:	In the NL	In the EU (2006)
Industry	20%	28%
Market and non market service sector	77%	67%
Highly skilled non manual worker	50%	-

Smulders / TNO, 2006

Hours of work	Amount	Percentage of total working population
> 12 hours per week	-	47%
< 12 hours per week	-	53%
On average (2004)	32 hours / week	-

Smulders / TNO, 2006

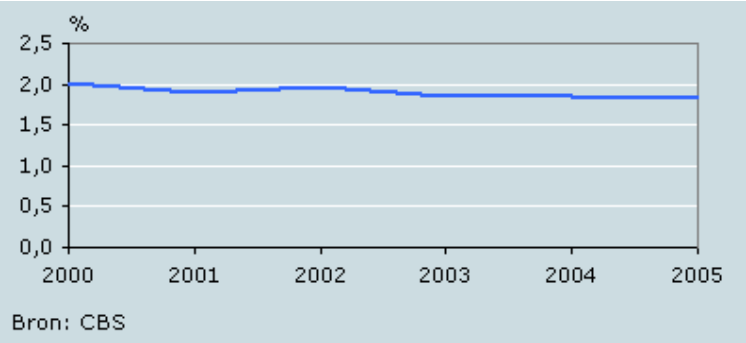
4.3 Work and health figures Netherlands

Before going any further into more specific aspects of work and health in the Netherlands, a general overview is provided drawn from a variety of data sources.

Occupational accidents	Number	Percentage
People who have had an industrial accident	140,000	1,8
Fatalities resulting from an occupational accident	93	-

CBS, data of 2005 respectively 2004

Trends in occupational accidents:

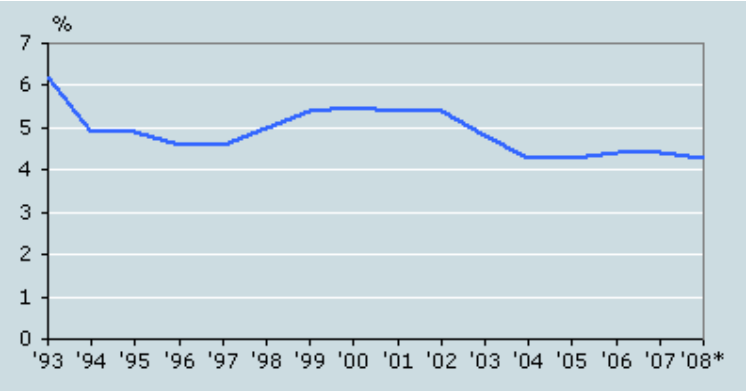


Source: CBS/Statline

Social security (averages)	Amount	Percentage
Absenteeism rate (2008) *	-	4,3
Total disability benefits (November 2009)	753,050	

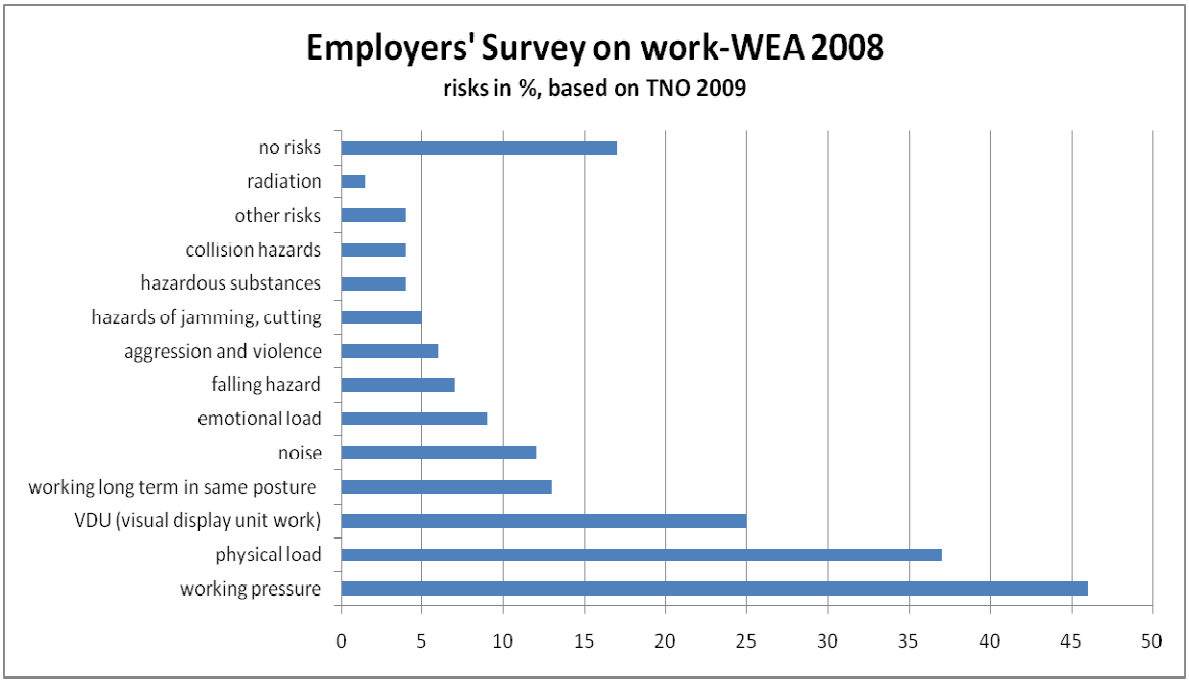
CBS/Statline, 2008 * The absenteeism rate is the total number of sick days for workers, in a percentage of the total number of available days in the same group of workers in the reporting period. The absenteeism rate is excluding maternity leave and from 2005 including the omission after one years illness.

Trends in **sickness absence leave** Netherlands: 1993-2008

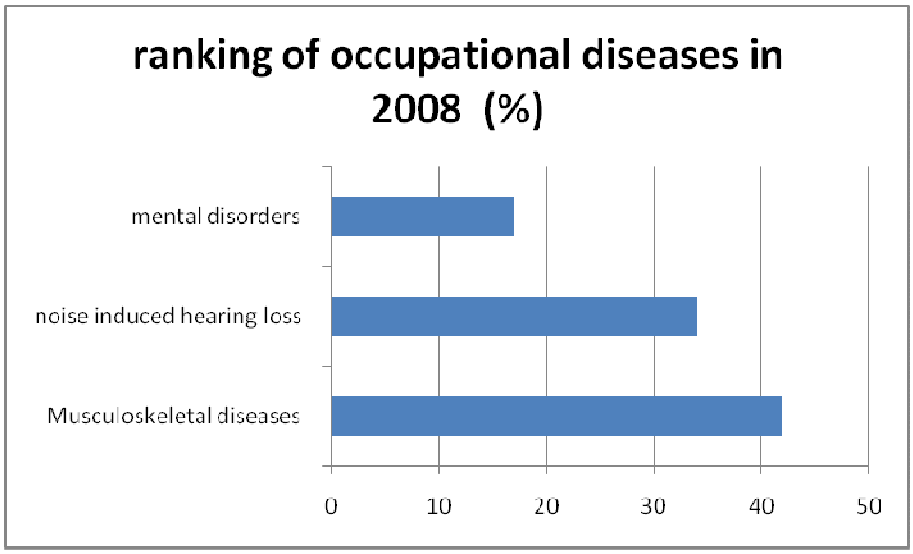


Source: CBS/Statline, John Kartopawiro – www.cbs.nl

Some figures on the **main work related health risks** in the Netherlands:

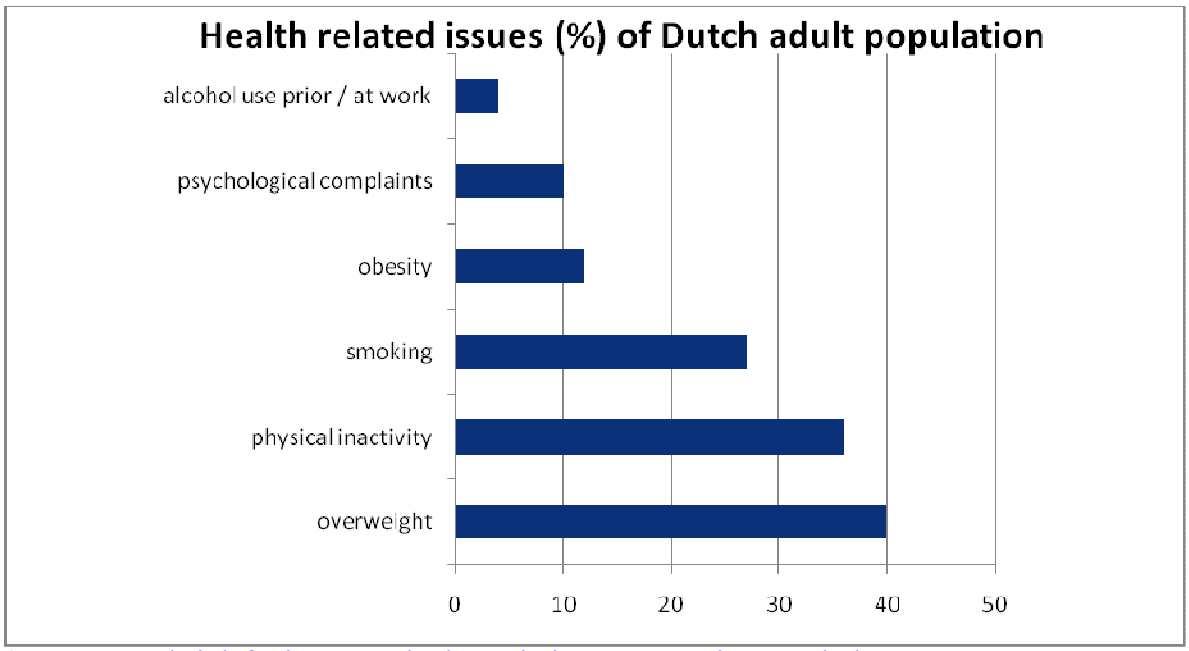


The ranking of **occupational diseases** in 2008:



Source NCvB (2009)

Some figures of **health related issues** of Dutch adults:



Sources: www.alcoholinfo.nl, www.psychischenwerk.nl, www.stivoro.nl, www.nisb.nl, www.convenantgezondgewicht.nl en www.tno.nl (Date of search, 10 February 2010)

5 The starting point: 'The Netherlands is sick'

5.1 Nearly one million people unable to work – 1989

'The Netherlands are sick!'

This famous statement of the former Dutch Prime Minister Ruud Lubbers was the start of major changes in social security in the Netherlands in the period of 1989 – 1994 (Cabinet Lubbers III). Especially in the laws on sickness and disability with more responsibility and accountability for employers and employees stimulated by financial incentives.

The sense of urgency was driven by fact of nearly 1 million people – about 1 in 6 of the Dutch working population – being labeled as "unable to work'" (1989). The term labeled is used deliberately. It is also important to note that at this time the social security system was also used as an easy and profitable way for "early retirement".

5.2 Working Conditions Act revision– 1994

This situation of a 'sick Netherlands' led to the revision of the Working Conditions Act. Before 1989, the focus was on safeguarding the safety of work, mostly addressing technical safety (see Annex 2 for highlights in work and health in the past). The new Working Conditions Act (Arbowet, 1994) required employers to provide a policy on work and absenteeism, and in addition to identify and address risks in the areas of safety, health and well-being in the workplace, and to take action to prevent or limit workplace hazards. Included in this was the implementation of a policy on absenteeism and protection of workers against sexual harassment, violence and aggression.

EU directive

The Dutch Working Conditions act is derived from the European Council Directive 89/391. The target requirements are included in the Working Conditions Act, the Working Conditions Decree and Labour regulations. The act, decree and regulation provide the minimum requirements for the health and safety protection of employees. Employees and employers must jointly agree on how the targets in the area of safe and healthy work are to be achieved. This gives room for a tailor made approach to OSH, when taking into consideration the specific risks and needs of the company.

Works Council

The works council plays an important role. Any Dutch company with at least fifty employees must have a works council. The works council or staff representatives must approve the OSH policy. The council also has the right of approval for the content of the policy on absenteeism. In small enterprises without a works council or staff representation, the employer consults with interested employees directly.

Obliged OSH tasks

Law requires the following OSH tasks at that moment:

1. Risk inventory: an assessment and evaluation of occupations risks (RI&E) and an action plan developed from the results of the risk inventory;
2. Absenteeism: support for individual employees and the development of a policy on sickness absence;
3. Regular employee health evaluation (PAGO): specific for occupational health issues, on a voluntary basis[3];
4. Recruitment examinations[4];
5. In-house emergency and first-aid service (BHV).

For companies the EU Directive also had financial consequences. Safety measures require expenditure, which has to be included in the calculation of production costs. This results in higher labour costs in the European countries and thus a less favorable position in the competitive economic market (level playing field in Europe).

5.3 TZ Arbo – 1994-1996

On the other hand, sickness and disability also lead to business costs. Parallel to the revision of the Working Conditions Act, the Sickness Absence (Reduction) Act (Wet Terugdringing Ziekteverzuim, TZ) was introduced to lower the economic impact of sickness absence. An additional act WULBZ (Extension of Obligation to Pay Salary (Sickness) Act) was introduced in 1996.

These laws stipulate that employers pay at least 70% of the wages during the first two weeks of sick leave. It was no longer possible to reinsure the waiting days (the first two days at the expense of the worker) or the non-statutory benefits (up to 100% salary supplement). Formerly,these insurances could be made by the business associations (bedrijfsverenigingen). As a result of this act, the responsibility for the supervision and the control of sick employees came to rest with the employer rather than with the trade associations.

Collectively the measures resulting from the revision of the working conditions act and the introduction of these new law are called 'TZ Arbo', as a symbol for more intertwining working conditions and prevention of absenteeism. The new measures place greater responsibility and accountability at the level of the company.

> *One of the experts strengthens that OSH care should focus on the occupational part of health care. For general care and prevention, we have a general public health care system*

[3] Additional to the PAGO, nowadays also a PMO exist: a preventive medical check up

[4] A recruitment examination in the Netherlands is only allowed by applying for functions in which specific medical conditions are required.

in the Netherlands. And the social security system focuses on the 'back' of care in case of disability.

5.4 Occupational health service provision – 1994

To safeguard the quality of the OSH policy, Dutch organizations were obliged to hire in external support. This began in 1994 with companies in industries with relatively high health and safety risk and became an obligation for all companies in 1998.

All occupational health services need to be certified, be they internal i.e. provided by OH staff employed directly by the company or external (OSH / Arbodienst) where the service is contracted out. This certification is comparable to ISO 9000 and undertaken by government appointed certifying organizations (Westerholm & Baranski , 1999 and www.sbca.nl).

The Works Council may decide on the choice of the external Occupational Health Services (Arbodienst), and on the contract with the health and safety or certified expert.

At that time, the emphasis for organizations was on sickness prevention and return to work, reaching the minimal requirements of the OSH law. This was also the focus of the external providers, brought into practice by four OSH specialists (so called 'kerndisiciplines') identified in the Working Conditions Act:

1. Occupational physician (bedrijfsarts)
2. Safety Officer
3. Occupational hygienists (arbeidshygiënist)
4. Work & organization professional (Arbeids & Organisatiedeskundige)

These experts were the basis of occupational health services, with a core role for the occupational physician. The expertise is supported by the use of guidelines, with the professional associations as the major player in improving the quality of expertise and consequently service delivery (see Annex 3 for more information).

In the above list of specialists, the most remarkable expert is the last one – the work and organisation professional. In no other European country is such expertise, focusing on the optimization of work, people and organization, present. The core expertise of this professional can be described in one word: 'well-being'.

The Dutch obligation of hiring in an external Occupational Health Services – if it was not provided within the company itself - was not in line with the EU directive and as a result the Dutch Government had to abandon this obligation in 2005.

Nowadays, the support can be delivered by an external occupational health service (Arbodienst) or by hiring in only specific expertise (customized support, 'maatwerkregeling'). This expertise can also be arranged 'in company' (internal OSH or Arbodienst).

At the moment there are 27 internal OSH and approximately 68 external occupational health services (www.sbca.nl/ February 2010).

5.5 Enforcement by labour inspectorate

The supervision of compliance with the Working Conditions Act is in the hands of the Labour Inspectorate (Arbeidsinspectie). Other issues covered by the inspectorate include compliance to working hours and the employment of foreign nationals.
The inspectorate investigates accidents and complaints made by employees and has the power of enforcement and the imposition of penalties.

The Labour Inspectorate's working area includes all companies and commercial and non-commercial (private and public) establishments in the Netherlands. The Labour Inspectorate is part of the ministry of Social Affairs and Employment.

This are the basic components for the current OSH policies in Dutch organizations, combined with the later on explained Dutch consensus model (7.2).

6 Additional social security laws

6.1 The effects of TZ Arbo

Over time, it appears that TZ Arbo has an effect on the disability benefits, both in terms of the amount of benefits (figure 2) and on the benefit expenditures shown in figure 3.

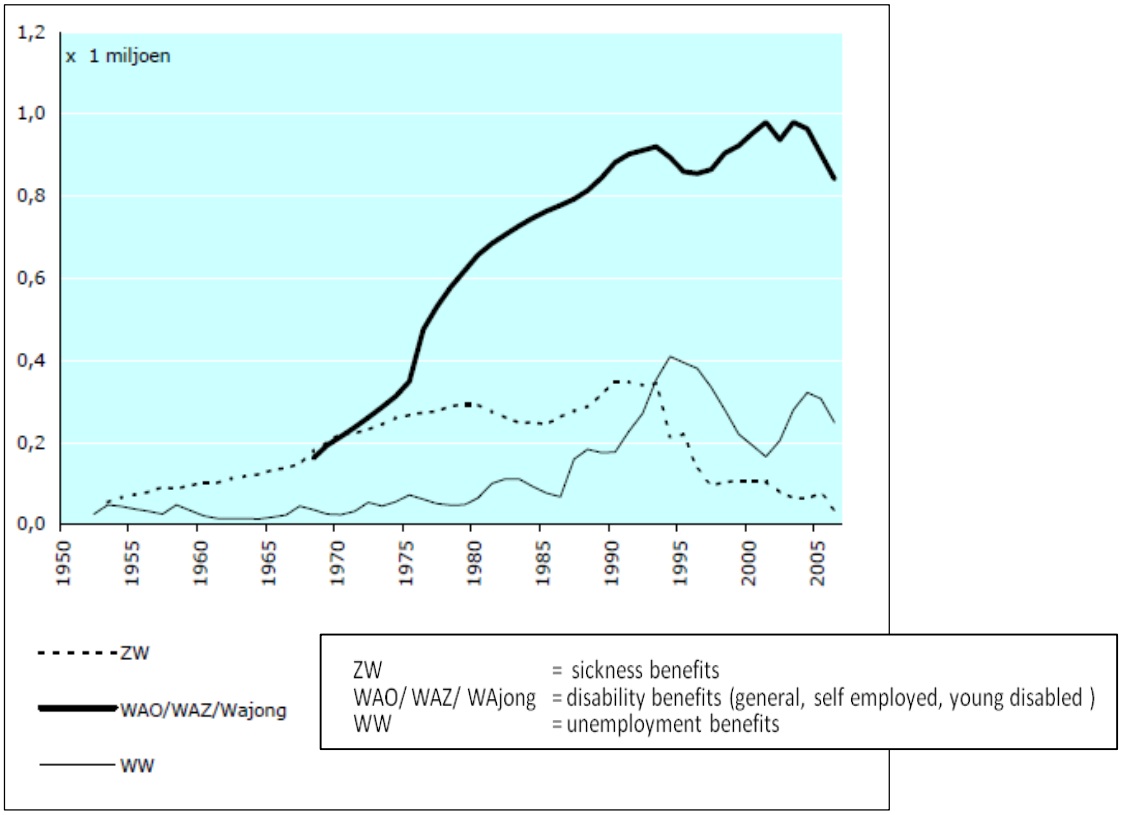


Figure 2: Amount of individual disability benefits in millions, 1950-2005 (UWV, 2007)

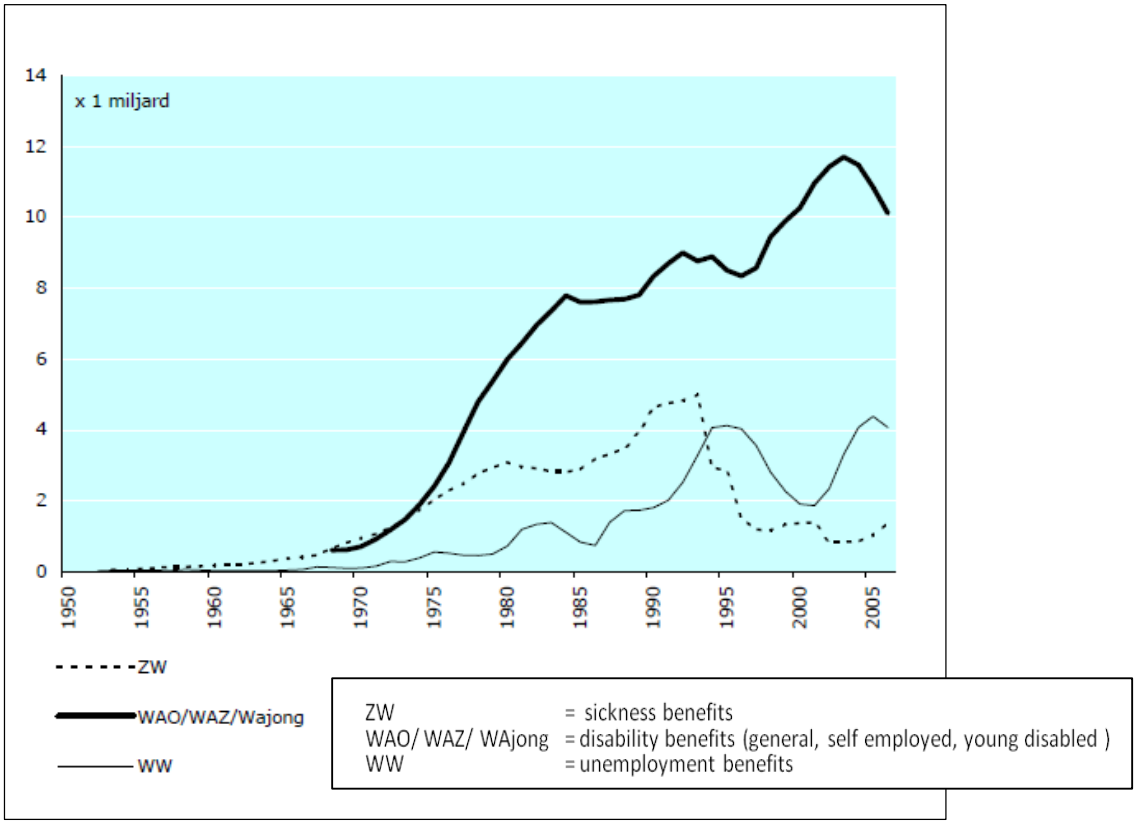


Figure 3: Amount of expenditures on benefits, in billions euro, 1950-2005 (UWV, 2007)

However the effect was short term and for this reason additional regulations (PEMBA and REA) were introduced in 1998.

6.2 PEMBA and REA (1998) - Gatekeeper 2002

The PEMBA concerns premium differentiation on disability[5]. The REA is a law concerning the re-integration of people with a disability (Wet op de (re)integratie arbeidsgehandicapten).

Both laws are aimed at workers who have been absent from work for more than one year. While the REA generates revenues by hiring and retaining disabled people, the principle behind the PEMBA is a financial penalty for employers, incremental in nature and related to the number of workers sick or disabled.

[5] PEMBA = Wet premiedifferentiatie en marktwerking bij arbeidsongeschiktheid

Gatekeeper (Permanent Invalidity Benefits Act 2002)

Later, in 2002, there commenced the 'Permanent Invalidity Benefit (Restrictions) Act' (Wet verbetering poortwachter), which contains further rules for both employers and employees in connection with long-term illness. The rules are obligatory. If they are breached both the employer and the employees face sanctions. The rules revolve around the planning and action taken to establish the workers' return to work. Documentary evidence is required as part of this process, it includes the creation of a re-integration dossier and a plan and a report of the re-integration process. The occupational physician has a central role as expert-consultant for all three parties, the employer and employee and as gatekeeper for the benefits agency.

The actual translation of the Dutch title of the law is Gatekeeper (Poortwachter). It is meant to regulate (to process) the entrance (restrictions) to the disability pensions or invalidity benefits.

With these actions, the Dutch government emphasizes de-regulation with financial incentives for more responsibility for enterprises and employees themselves. De-regulation is one aspect. Self-regulation and having more influence on the content of the policy and activities are other aspects.

In the Netherlands the law sees on absenteeism regardless the cause; there is no distinction of professional risks, private or social risks.

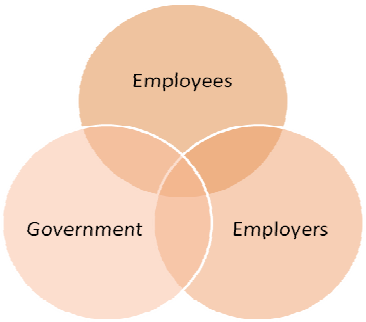
7 Soft Laws – Arbocovenants

7.1 Arbocovenants – 1999

To meet the employers' need for more tailor made policy on health and safety, the soft law program (Arbocovenants, in Dutch Arboconvenanten) was begun in 1999. In summary it means employers, employees and government working together intensively to improve working conditions. Exposing the famous Dutch 'polder' model.

7.2 Dutch Polder Model

The Dutch consensus model is the tripartite party method, involving trade unions, employers and government, searching for consensus and reaching agreements on work. In Dutch called, the 'polder model'. The Duch triad:



The Wassenaar Agreement (24 November 1982) is seen as the starting point for this consensus model on work aspects, more specific in this case on wage moderation in exchange for shorter working hours. The agreement was signed between the Dutch government and the organizations of employers and employees who were represented in the consultative Labour Foundation (Stichting van de Arbeid).

The Consensus model is the basis for the Dutch system on work regulations, with the Social and Economic Council of the Netherlands (SER) as the formally body to advise the government.

7.3 Soft 'law'

The soft law is called 'soft' because the government is involved and supports the initiatives of employers and employees: the agreements are not regulated via law. This is remarkable and a very specific Dutch initiative.

The objectives of the soft law are to: improve working conditions, reduce absenteeism and lower the number of people incapacitated due to work. Trade unions, employers' organizations and governmental organizations sign up to these goals. In such, the soft law functions as a tripartite agreement on reducing work hazards.

Examples of the focus of the soft laws:

- Aggression;
- Industrial disputes;
- Hazardous substances;
- Psychological stress;
- RSI / CANS (complaints of Arm Nek Shoulder);
- Noise hazards;
- Physical load;
- Workload and re-integration.

7.4 Successful soft law approach 1999 - 2007

The evaluation of the soft law initiatives shows a successful program (Tripartiete Werkgroep Arboconvenanten, 2007). The following results were obtained in the sectors with a known Arboconvenant during the eight years of soft law:

- Absenteeism decreased with 28 percent in the involved sectors (in other sectors 11 percent);
- The additional reduction in absenteeism in sectors with a soft law agreement saves the sectors €450 million per year;
- Furthermore, sectors with a soft law are more willing than they were previously to improve working conditions;
- They also gained more knowledge on how to tackle issues on working conditions;
- Sectors with a voluntary arbocovenant also have more agreements over measures to be taken against certain risks such as occupational RSI, pressure and aggression and violence.

In the eight years of the Arboconvenanten program (1999-2007) 69 agreements were completed, in 55 sectors, resulting in a coverage of more than the half of the Dutch employees.

Commitment of social partners, the Ministry of Social Affairs and Employment, researchers and practitioners in the sectors is one of the success factors. However, there was also criticism, namely that the soft law was created 'behind the desk of governmental clerks' and was not of a practical nature .

Overall, it showed that even though not all goals are reached within the Covenants strategy, the approach seemed to be a good basis for developing Arbo Catalogs (Arbo New Style, 2007), thus

providing a new opportunity for healthy and safe working in sectors with optimal freedom for developing tailor made programmes in enterprises.

7.5 Proportional enforcement policy

The governmental policy on OSH becomes proportional so that in the case of work which has greater risks for the health and safety of employees a higher level of compliance, and meeting an increased number of requirements is required of employers. For example, a small business with only a couple of employees it is sufficient to using a digital Risk inventory (RI&E, www.rie.nl). However in comparison, a process industry with proportional higher safety risks, as to fulfill a so called additional Risk Inventory and Evaluation - ARI&E, and this involves the use of experts. These are specialized projects, with a certain duration and expenditures.

8 Focus on prevention and work capacity

8.1 Internal Prevention Officer

As mentioned previously (5.4) a consequence of the judgement of the European Court was that the obligation of hiring in an external occupational health services was removed in the Netherlands in 2005. In order to safeguard employees and therefore the expertise in an organization an obligation was included in the Working Conditions Act, namely to consolidate the responsibility for health and safety into the role of employees. For organizations with more than 25 workers this means that there is a requirement to have at least one internal Prevention Officer (Preventiemedewerker).

This change increases responsibility in organisations and enables the tailor made approach adopted by organisations in the Netherlands. In many organizations, the existing health and safety coordinator fulfils the role of the prevention officer. In small enterprises with less than 25 workers, the role of prevention officer is fulfilled by the employer.

> *The abolishment of the obliged hiring in, had an effect on the contracts with occupational health services. In 2007, 79% of the companies have a contract with an Arbodienst / external occupational health service. In 2005 this was 86%.*
> *Source: Survey on work and health / Arbobalans 2007/2008 (TNO)*

8.2 Focusing on work ability - introduction of WIA - 2005

The social security system in the Netherlands emphasises the need to focus on employment and healthy working conditions rather than on sickness and disability. The emphasis of the Labour Capacity Act (WIA) is what people still can. The WIA consists of two parts: the partial resumption of work scheme (WGA) and the income provision scheme for those who are completely incapacitated (IVA). Through financial incentives employers and employees are encouraged to sustain employment (WGA). At the same time there is income protection for people who really can not work (IVA).

Annex 4 is a table setting out the main changes in social security provision over time. Over time the increased emphasis of maintaining employees capability to work is also seen in the names of laws and regulations. Was it formerly the Disability Act WAO, in 2005 the Work and Income according to Labour Capacity Act (WIA) is active.

The introduction of the Workers Capacity Act in 2005 led to the REA requirements being revoked and in 2008, the premium differentiation PEMBA was retrospectively abolished as of 2006.

8.3 Well-being out of the Working Conditions Act - 2005

In 1989 well-being was one of the big three topics addressed by the Working Conditions Act: improving the health, safety and well-being at work. Additionally the Working Conditions Act

introduced an instrument for measuring well-being: the WEBA (WElzijn Bij Arbeid, Well-being at work).

However in 2005 well-being is taken out of the Working Conditions Act. The phased introduction of required OSH activities supported by OSH professionals on the one hand, and new social security regulations on the other (PEMBA, REA, WULBZ), provided the stimulus for employers to take ownership of these issues themselves. Following this same line, it is considered that only using the terms of health and safety are sufficient enough.

9 Arbo New Style – 2007

9.1 Working Conditions New Style

January 2007 saw the commencement of a new phase of action - 'Working Conditions New Style', in which employers and employees were given greater responsibility and increased opportunities to customize working conditions within their industry or their company, and thus to improve the safety and health at the workplace. The government assigns objective requirements which are interpreted and translated into action by employers and employees within their company or sector. This approach has been developed in the new Working Conditions Act.

The most important changes in the new Working Conditions Act are:

- Less regulation;
- More responsibility and accountability for employers and employees;
- The requirement to provide specific OSH consultation hours by company doctors has been removed, now employers have to provide employees access to any OSH professional;
- The review of the Risk Inventory is changed. For organizations with less than 25 employees, a review by the occupational health services is no longer required (before this was the case for less than 10 employees);
- The Risk Inventory instrument is now part of the collective agreements in the sector and the instrument is reviewed by at least one OSH expert;
- The yearly report based on the Risk Inventory is replaced by regular communication and actions by the employer together with the Works Councils
- The scope of psycho social working load is broadened: besides sexual harassment, aggression and violation, the OSH policy in companies is obliged to focus also on the prevention of mobbing and work load.

The Legal obligations of the Working Conditions Act are:

- The development and implementation of Working Conditions Policy (Arbobeleid)
- Possible health risks should be avoided through a fundamental source approach
- Workplaces, working methods, equipment used and work content should be as much as possible adapted to the characteristics of the employees. This also applies to workers with a structural functional limitation (for instance) due to illness
- To prevent and reduce as much as possible monotonous and pace bound work

- Conducting a risk inventory and evaluation (RI&E) and a plan of action
- Prevention and mitigation of major accidents involving dangerous substances
- Providing information and education to employees.
  Information and training can relate to the use of equipment or personal protective equipment, and also how the company engages with aggression, violence and sexual harassment
- Reporting and recording of occupational accidents and diseases
- The prevention of danger to others in connection with work performed by employees
- Cooperate with workers council, staff representatives or employees concerned
- The appointment of expert workers as a prevention officer, company helper and occupational health expert. These expert workers can support the implementation of the RI&E and providing first aid
- Involvement of a (freelance) health and safety service or certified occupational health expert, to support the absenteeism policies and auditing the RI&E
- Offering employees regularly (work) health checks

The instrument belonging to this new style approach is the Arbo Catalog.

9.2 Arbo Catalog

The Arbo Catalog contains the agreements made by employers and employees about safe and healthy work and the initiatives to be taken to reach the requirements of the Working Conditions Act. In short, an Arbo Catalog documents risks and customized solutions, describes techniques and methods to achieve set goals, provides best practice standards and practical guides for safe and healthy working.

An Arbo Catalog can apply to an individual business or for an entire industry or sector. Once a catalog is created and approved by the government, the OSH policy rules for that sector. The Labour Inspectorate monitors business compliance with the law and regulations, taking into account the solutions in the Arbo Catalog.

As of September 2009, 57 Arbo Catalogs were approved, covering about one third of the Dutch Working Population. The goal is that within a few years all sectors will have their own Arbo Catalog. Once this is the case the OSH regulations will expire.

9.3 New inspection of the Labour inspectorate

The Labour Inspectorate uses existing statute and regulations to monitor the Arbo Catalogs and the implementation by employers and employees. The new inspection is a more outcome-oriented approach and more tailored to the business.

The basis of this inspection and enforcement regime is the managing principle: 'Hard when needed, soft where possible'. The company review is based on the severity and extent of the risk, the health and safety history of the company, and the willingness and ability of the employer to act.

A second important element of the new inspection system is that of tackling priority risks with tailored projects and specific guidance containing information about the most important risk factors in the sector and the obligations of employers and employees.

9.4 Mindset: more attention for behavioural factors

A further development has seen more attention given to behavioural aspects of health and safety. In the risk inventories the change can be seen as a move from a purely technical inventory to one that focuses on organizational process highlighting the role of safety managers and giving much more attention to the role of behaviour in safety.

> *For example, in February 2010 the professional associations held a conference with the name ' Behaviour as forgotten factor [in health and safety]'*

This focus has also shifted to the prevention of absenteeism. Two frequently used sayings clarify this societal mind shift:

1. 'Illness happens to you, absenteeism is an option';
2. 'The first day of sickness, is the first day for taking action to return to work'.

9.5 Changing profiles of experts

In line with the developments in the law relating to working conditions and the changes in the social security acts, the experts on work and health are changing their profile. From the originally legally driven actions on sickness and risk prevention, with a company doctor for individual health problems, the focus is now on how health is impacted by the working system as a whole, with the need to maintain and promote health and keep employees fit for the job and able to participate in work seen as a priority. OSH and other experts now support employees so that they maintain their employment, and advise employers and organizations about policies on work and health in general.

> *For example, in 2007 the Netherlands Society of Occupational Medicine positioned the occupational physician as 'doctor and consultant'. The motive for renewing the position and tasks of the OP were the developments within the working field of the company doctor,*

including the WIA (Work and Income according to Labour Capacity Act) and the growing emphasis on participation and prevention in companies.
One of the formulated tasks of the O.P. is: 'Advising the labour organization (employer and employee representation) in (system) prevention, vocational and occupational hazards and organizational aspects relating to human resources' (Source: NVAB, 2007).

Also the professional guidelines have become much more action oriented, with a timetable for focusing on return to work, employee and employer participation and the prevention of disability.

The occupational physician still is the only medical expert in the field of work and health. A trend is that more and more company doctors are becoming self-employed.

9.6 Joint initiatives

Another trend has seen much greater levels of cooperation between professional associations, despite questions about domains and who does what and where

An example is the foundation PPM -Prevention Project Management.
PPM is a partnership between the professional association of work and organizational professionals (BA&O), occupational hygienists (NVvA) and the safety officers (NVVK) for joint initiatives. Together with the professional association of occupational physicians (NVAB) they coordinated a project for a digital portal on work and health issues for public (www.arbokennis.net and www.arboportaal.nl)

This collaborative working has resulted in the production of multidisciplinary guidelines such as the: LESA on Adjustment Disorder and Burn-out (published in January 2005), a joint initiative of the Dutch College of General Practitioners (NHG) and the Netherlands Society of Occupational Medicine (NVAB).

The multidisciplinary approach within occupational health is seen as a quality improvement (Westerholm & Baranski, 1999).

10 Prevention

In line with the health continuum (paragraph 4.1), prevention focus on an active approach of disease prevention for groups at risk.
The description of prevention and work, will focus on two aspects that are closely interlinked at the workplace:

1. Prevention
2. Prevention of disability

10.1 Prevention

In the Netherlands the two primary organizations with a prevention role are:

- GGD:
  The municipal health service is available to each municipality in the Netherlands and has a number of tasks in the field of public health. These include monitoring, protecting and promoting the health of vulnerable groups, including children, youth and elderly applicants.
- RIVM:
  The National Institute for Public Health and the Environment is a centre of expertise in the fields of health, nutrition and environmental protection, working mainly for the Dutch Government. RIVM provides research, monitoring, modelling and risk assessment used to underpin policy on public health, food, safety and the environment.

10.2 Workplace and prevention

One of the settings mentioned by both GGD Netherlands and RIVM is the workplace. It is recognised as a community and as a way of reaching the Dutch inhabitants with the health protection and health promotion messages.

At the moment, specific occupational prevention interventions initiated by the public health domain are rare. A notable exception is the Mexican flu outbreak (2009). Most organizations stimulated hygiene procedures for both employees and customers, and some organizations provided employees with a free vaccination on voluntary basis. But even for groups at risk – such as employees of hospitals, nursery homes and emergency care - the vaccination was on a voluntary basis.

There may be some promising experiences of the Convenant Gezond Gewicht / Covenant Healthy Weight. An initiative of the Ministery of Health, Welfare and Sport tackling the problem of increasing overweight together with partners in the community. One of the pilots is introducing the Epode method for young people in the Netherlands which will combine environmental measures with changes in the behaviour - in this case the eating and physical habits of young people –

thereby preventing overweight and obesity. In the context of environmental change, the whole environment to which children are exposed will be involved - municipalities, schools, parents, play grounds etc. If the Epode pilot is successful it could become a successful method for health promotion for another target audience of the Covenant Healthy Weight, namely those in employment (Raaijmakers, 2009).

10.3 Prevention of disability

The guidelines for professionals, mostly for the occupational physicians, are targeted at preventing disability. There are also groups at risk due to the characteristics of the work. The Netherlands Center for Occupational Diseases (NCvB) is the knowledge center on these topics. The Centre provides summaries of research reports, gives insight into the developments of working conditions and occupational diseases, and describes preventive interventions in the various sectors and their effects. The NCvB also provides guidelines for registration, consisting of diagnostic and reporting criteria for occupational diseases (since 1999 occupational Physicians are obliged to report occupational diseases to the NCvB).

An overview of the registration guidelines:

A. diseases caused by chemical agents
B. diseases caused by physical agents
C. work-related infectious and parasitic diseases
D. work-related musculoskeletal disorders
E. work-related mental disorders
F. occupational skin diseases
G. professional Pulmonary diseases
H. work-related neurological disorders
I. work-related defects of the eyes and nose
J. Rest Group

10.4 New risks and vulnerable groups

The NCvB foresee new risks and newly vulnerable groups. An ageing population, the improved treatment of chronic diseases and a focus on re-integration all mean that an increasing numbers of people are continuing to work despite having compromised immunity. These people are especially vulnerable to biological agents.

Some multinational companies have also become aware of these developments and have sounded the alarm about the impact of lifestyle on the economic situation of companies caused by failure to

work and absenteeism as a result of physical complaints e.g. obesity and Type II diabetes. The concern is that lifestyles must improve because the current generation of young people has a shorter life expectancy than their parents. Issues highlighted in the report, "Working towards wellness" (World Economic Forum, 2007) developed by PricewaterhouseCoopers Health Research Institute in collaboration with several multinational companies.

11 Workplace Health Promotion

Workplace Health Promotion (WHP) is defined as: *'The combined efforts of employers, employees and society to improve the health and well-being of people at work (Luxembourg Declaration, ENWHP 1997)'.*

Workplace Health Promotion involves:

- Having an organisational commitment to improving the health of the workforce;
- Providing employees with appropriate information and establishing comprehensive communication strategies;
- Involving employees in decision making processes;
- Developing a working culture that is based on partnership;
- Organising work tasks and processes so that they contribute to, rather than damage, health;
- Implementing policies and practices which enhance employee health by making the healthy choices the easy choices;
- Recognising that organisations have an impact on people and that this is not always conducive to their health and well-being.

11.1 Dutch Centre Workplace Health Promotion

The first specific initiative on WHP in the Netherlands was establishment of the Dutch Centre for Workplace Health Promotion (1995-2003), initiated by three health organisations: the Netherlands Heart Foundation, the Netherlands Asthma Foundation and the Dutch Cancer Society. The motto of this centre was: Make health an integral part of good business practices (Baart et al., 2003).

The activities of the Dutch Centre for WHP were focused on:

1. Lifestyle interventions;
2. A process oriented approach for health at work;
3. Policy initiatives.

Behaviour and environment

The lifestyle interventions concerned 'healthy employees in healthy environments', with an individual approach on health behaviour in combination with adjustments in the working environment.

One of the experts indicated that in the Netherlands the government on health is directed from sickness and care (Ziekte & Zorg) towards Health & Behaviour (Gezondheid & Gedrag).

7- step method and IGM

The approach introduced in the Netherlands consisted of a seven step model – derived from the international step model on WHP (Wynne et al, 1996):

Step 1: Building up support

Step 2: Setting up a structure

Step 3: Needs analysis

Step 4: Developing a plan

Step 5: implementing the plan

Step 6: Evaluating the plan

Step 7: Consolidating WHP

The 7-step programme was translated for specific themes of WHP, such as physical activity, pulmonary disease, healthy food, hazardous substances, green plants at work and repetitive strain injuries (RSI/CANS). Free materials were available for workers and employers .

In 2003, the Centre and TNO developed the concept of integral health management (IGM, Zwetsloot et al., 2003). With seven lines of development:

1. Health as a strategic theme,
2. A healthy primary process,
3. A healthy physical (work) environment,
4. A healthy social (work) environment,
5. Healthy people,
6. A healthy relationship with the immediate environment and
7. Healthy products and / or services

In 2003 the Centre merged with health institute NIGZ and workplace health promotion remains as one of NIGZ themes , especially within the healthy schools programme.

11.2 National contact office for ENWHP

The Dutch Centre WHP was a member of the European Network for Workplace Health Promotion (ENWHP) and the National Contact Office of this network in the Netherlands. At the moment, TNO Quality of Life / Work & Employment fulfils this function. TNO Work and Employment activities are research and consultancy in the field of occupational safety and health (OSH). Integrated health management, in short 'healthy business', is one of the topics.

Recently, there was the campaign Move Europe, based on lifestyle. The current initiative is called 'Work in tune with life' and it addresses mental health issues at the workplace.

11.3 Role of Trade unions and Employers' organizations

The trade unions and employers' organizations are mainly focusing on the basic requirements of the working conditions act. One expert of the trade union once explained the importance of workplace health management as follows: 'It is the whipped crème on top of the cake. Whereas the cake is fundamental for safe and healthy working conditions'.

11.4 Private providers – health screening and BRAVO

At the moment, mostly private organisations such as occupational health services and consultancy firms provide WHP activities. Insurance companies also play an important role, providing lifestyle interventions. Health promoting organisations, such as STIVORO (smoking) and NISB (physical activity and sports) have close connections to insurance companies, resulting in compensation for smoking cessation, and the Beweegkuur – a treatment for diabetes patients focused on increasing levels of physical activity – with these now included in basic health insurance.

Health screening is one of the primary products. The implementation of one of these screening methods – the workability index / WAI - is supported by the Ministry of Social Affairs and Employment. The organization Blik op Werk coordinates the licences and implementation of the WAI.

The activities are around the so called 'BRAVO' approach:

- B stands for (more) physical activity (Bewegen),
- R stands for (less) smoking (Roken),
- A for (moderate) alcohol use,
- V for (healthy) food (Voeding), and last but not least,
- O for relaxation (Ontspanning)

11.5 Integrated health approach

Besides lifestyle interventions and screening, the trend is towards integrated management with an integral management accountability for employee health and facilities for employees to take

responsibility for their own health (at work). Resulting in appointments on these issues in the collective agreements (CAO).

This integrated approach is interlinked with the quality systems of the organization, such as EFQM (European Foundation of Quality Management) and with organizational developments such as corporate social responsibility (CSR) and employability. These issues are included in accreditation and award schemes for integrated company health policy . Such schemes include:

- Employers' Forum Kroon op het Werk – with a focus on people with work disability, prevention of absenteeism and facilitating return to work;
- iHMQ (International institute for Health Management and Quality) – with as its basis the EFQM model (European Foundation of Quality Management) and the working principles of appreciative inquiry;
- IiP - Investors in People – with a focus on learning, personal development and employability;

Explicit standards are now appearing on these topics, e.g. the practical guideline 'Managing sustainable employability' developed by the Dutch Standardization Institute (NEN, 2010 in press).

TNO is developing for the Ministry of Health, Welfare and Sports an integrated health method for small and medium sized enterprises (Gründemann et al., 2006).

11.6 The reach of WHP

A survey commissioned by the NIGZ (TNS-NIP, 2004) shows that about one in four Dutch companies is active on workplace health promotion. What is striking in this research is the difference between large and small businesses: the larger the company, the more it is active in the field of health management.

The initiatives vary from individual activities to a comprehensive policy, with more focus on activities on specific lifestyle themes. The most common themes are:

- smoking (55%);
- alcohol (33%);
- sick leave policy (30%);
- movement (28%).

11.7 The business case of WHP

Within the European Network for Workplace Health Promotion, a business case for WHP has been made (Greef de & Broek van den, 2004). The study reveals three important drivers for the business case of workplace health promotion:

1. Corporate values which recognize the social and economic relevance of a participatory workplace culture;
2. Social and demographic trends with significant impact on the labour market as external drivers;
3. The impacts of workplace health investments along the employee-customer-profit-chain also highlighting the role of workplace health investments for improved business processes.

Benefits for employees

It is now widely accepted that a healthy working environment improves the health and well-being of employees. Providing a better quality of (working) life, more energy, an increasing employability, improving changes on the labour market.
It also results in reduced risk of accidents and occupational diseases and of disability due to work.

This is especially the case when workplace health promotion is an integral part of the management culture with employee health and well-being consolidated in all policy and activities of the organization.

Benefits at company level

The improvement of the organization of work and the working environment also has an effect on the company. Employee health and well being is improved, and there is a positive effect on the motivation of employees. These result in greater engagement, a stronger bond with the organisation, higher quality of products and services, less errors in production and services, increased production, more innovative capacity and therefore a better position on the competitive market. The company is also seen as being an attractive employer – a strong position to be in with regard to the labour market.

Companies also incur lower costs in terms of supplementary wages for sick employees (e.g. continuation of wage payment during sickness) and a reduction effect on the non-wage labour costs.

In addition, the reduction of absenteeism and disability diminishes social security costs.

Benefits for social insurance organizations

The benefits that accrue at company level, also impact positively on the social insurance systems and health and accident insurance funds. This leads to savings in public health service expenditure.

There are also benefits to pension insurance, which is important in the Netherlands with proposals in place for working on until 67 instead of 65 years. In practice, the current average age of retirement is 61 years (CBS, 2006). The discussion in the Netherlands is on the so called 'heavy jobs', in which people are not reaching the average age of retirement. The business case points out that workplace health management can be a substantial factor in enabling workers to remain employed throughout their working life.

PricewaterhouseCoopers also came to these conclusions and signalled that WHP is an important aspect of coping with these new challenges, making the link to employability, social security and OSH in the Netherlands (PricewaterhouseCoopers, 1998).

11.8 Developments of WHP

The trends in WHP are remarkable. Unfortunately it is not uncommon for companies and other organisations to demand an economic or financial business case before any WHP activity can commence. This leads to an emphasis on measuring individual "health" indicators, most of which are risk factors for disease such as high blood pressure, overweight and triglyceride and their effects on absenteeism. The possibility of obtaining “hard” financial figures.

In contrast to this development is the strong view that health is the result of many factors, largely outside the (occupational) health care system. These effects are long term and these factrs that lead to them are addressed in the health-in-all-policies perspective that is also reflected in the WHO global plan (2007).

This leads to a strange contradiction and key performance indicators on (workplace) health are not yet fully in place. It also requires a more system based approach. An example of this is the programme ‘workplace health promotion within the Knowledge network for System Innovations and Transitions (KSI network)’, a collaboration between Wageningen University and BaartRaaijmakers (Bakker et al. 2010, in press).

The system approach is not new. The very old Models of Good Practice such as Philips and the Stork Factories (Annex 2) show that a combined effort on business and social aspects, with leadership focusing on the vision ‘health = wealth” for all, beneficial for business, workers and society. This kind of organizations talk rather about stakeholders instead of shareholders.

12 Afterword

We would like to end with the most recent visions of the three parties in the Netherlands on work and health, as presented on a conference on 'Work is still healthy…?!'[6]

Ab Klink, The Dutch Minister of Health, Welfare and Sport states that the health protection of the Dutch employees is safeguarded. The promotion of health and participation remains behind. The minister emphasizes the introduction of new definitions of health and disease in the Netherlands. In which health is truly health, as defined in the WHO Ottawa Charter (1986) in sense of opportunities and possibilities for people to have control of their own (working) life and health. And providing companies with knowledge and tools to reach health promotion, in addition to occupational health care instead of new laws and regulations. The new program Participation and Health, initiated by the three ministries of Health, Welfare and Sport, Social Affairs and Employment and ministry of the Interior and Kingdom Relations can be a essential in this.

Bernard Wientjes, the president of the largest Dutch employers' organization VNO-NCW, wish to express but a small role for the government, there is no further need for laws or regulations. It is of self-interest that companies invest in the health of employees due to a declining labour capacity and of reasons of corporate social responsibility. VNO-NCW focuses on diminishing the remaining unsafe and 'disabling' working conditions such a physically demanding work. Wientjes also advocates more incentives stimulating sustainable employment over different organizations: at the moment the system is still focusing on employment with the same employer e.g. salary scales, pension system and dismissal constructions. It also requires permanent education of working people, capable switching work.

Agnes Jongerius, president of the largest Dutch trade union FNV asks permanent attention for the working conditions, especially for the lower working class (in the Netherlands about 2.5 million people) still facing 'un decent' work. The recent trend providing individual health checks bears the potential risk that health is the sole responsibility of individual workers. and employers withdraw from their responsibility on prevention. Jongerius pleads for things in the right order: first safe and healthy working conditions, before making the move to attention for individual health.

Jongerius plead for things in the right order: first safe and healthy working conditions, before making the move to attention for individual health.

[6] The Boaborea –the association of the occupational health and re-integration services- organized this conference on 31 March 2010.

Annex 1 Experts

- Drs. Paul Biemans, senior advisor, Directorate of Working Conditions, Dutch ministery of Social Affairs and Employment
- Marc Dijkstra MA RA, Chief Financial Officer ArboNed / director KeurCompany
- Willem Dollekamp MBA, director Krehalon - Food Packing Industry
- Prof. Dr. Monique Frings-Dresen, Principal Investigators Occupational health and diseases – Academic Medical Center Research / University of Amsterdam – Head of Coronel Institute Work and Health
- Jaap Koot MBA, director NIGZ – Dutch Health Institute
- Danielle Schiet MA, Deputy Head of Directorate for Health and Safety at Work, Unit General OSH Policies - Dutch ministery of Social Affairs and Employment
- Dr. Ir. Cees Vos, senior advisor research policy and knowledge management at Ministry of Health, Welfare and Sport
- Adriaan Weber, Policy Officer, Directorate for Health and Safety at Work, Unit General OSH Policies - Dutch ministery of Social Affairs and Employment

Annex 2 History health and work in the Netherlands – in brief

A number of important historical milestones in the field of working conditions provide insight into the development of occupational health care who runs alongside:

1841	**Survey on the circumstances of the working class**, in particular the widespread child labor. Often children over 12 years were sent to workshops, where they were faced with monotonous, heavy work for long days.
1874	**Kinderwetje van Van Houten**, in translation: Law on measures to combat excessive labor and neglect of children.
1886	**Parliamentary inquiry** regarding the prevention of excessive work and about the state of factories and workshops to ensure the safety, health and welfare of workmen. This was the first time not only to the conditions of child labor were considered, but also the safety and health of workers in general (the survey in 1841 was mainly focused on child labor). Not all workers were happy with this survey, impartiality was feared because no workers were involved.
1889	**Labor Act (Arbeidswet)** with a ban on employing children under twelve years, a ban on Sunday and night work for women and persons under fourteen years, an eleven hour working day for 'young people' from 12 to 15 years and an eleven hour working day for women. The act excluded adult men (including adolescents from 16 years). They were not regarded as the "economically weak", and are seen as sufficiently 'man' to defend their own interests.
1890	To supervise the enforcement of the laws, the **Labor Inspectorate (Arbeidsinspectie)** was installed. This meant that the State recognized that it has a role in the protection of civilians around work and health.
1890	Establishment of the `**Association for Prevention of Accidents** in Factories and Workshops'. And in that same year the first conference in Amsterdam in this area: "First Dutch Exhibition to Promote Safety and Health in Factories and Workshops".
1895	**Safety Act (Veiligheidswet)**: protection of all workers (including men and boys) followed from the Security Act. Such a law was needed: in the annual report of 1891 the Labor Inspectorate reported approximately two thousand serious accidents where 54 workers were killed. At that time, the working population was around 2 million people. The Security Act contained provisions to protect workers in factories and / or workshops with power tools and more than 10 employees. Similar to the Labor Act (Arbeidswet), not all employees were content with the Security Act. They

	feared the loss of income by applying the law, as in the case of (reduction or elimination of) overtime. And a number of security provisions was considered "childish" and thus as "insulting" to the worker.
1897	Design of the **Compensation Act (Ongevallenwet)**. The law came into force in 1901, hence the law is mostly referred to as the Compensation Act 1901. Although this law considered compensation for loss of income through work related sickness and social security, the Compensation Act has also major impact on the institutionalization of working relations in the Netherlands. As stated in the **pacification article**: "This new law will extend peace to the unpleasant and hateful processes between laborer and employer to help the world".
1899	The **Dutch Association of Employers** (VNW, Vereeniging van Nederlandsche Werkgevers) was founded by 52 manufacturers, on the initiative of the largest employers of that time: the industrial Dirk Willem Stork (Twente) and the manufacturer Jacobus Cornelis van Marken (Delft). The Compensation Act was the reason to unite. This was not so much the requirement to have insurance against accidents. The opposition was mainly against the mandatory way in which employers had to reassure the risk by including this in the National Insurance. The industrialists wanted freedom of choice in this area. It can be said that the Compensation Act led to the creation of the first national employers organization.
1906	Mandatory establishment of **working committee/ works council of 100 plus companies**. The requirement comes from the Mines Rules (Mijnreglement), where such a labor commission was compulsory for companies with more than 100 employees. The task of the working committee was as follows: "... whose mission is, wishes, concerns and complaints regarding safety, health and work, so far that it appears well founded, to notify the directors of the mine." In a number of other companies already working committees were active on a voluntary basis, such as in the Yeast and Spiritus factory of Van Marken in Delft (1878) and in the Stork engineering factory in Hengelo (1883). In 1906 the Dutch Trade Union Confederation created the forerunner of today's unions.
1909	**General Administrative Decree 'Controller of work'** (AMvB 'Controleur van de arbeid') Firstly as a response to the inadequate monitoring of Labor Inspectorate due to lack of time and manpower. And secondly by the resistance of workers against the legislation on labor safety for the fact that they were not involved. In 1909 in a General Administrative 'Controller of work' was set. With the added definition: "Sufficiently developed workers, who have learned to know the businesses thoroughly, will more often than any other provide information about the

	importance of labor regulations. Their experience will usually be able to contribute, that measures be taken, which at the least sacrifice on the part of the employer cause the most useful effect for the worker". The auditors were not appointed by the workers themselves or for example the union: they were officially appointed as official of the Labor Inspectorate.
1919	**Labor Act (revision**), with as main achievement the right to an eight-hour workday, for each employee (also men). Although the number of hours during the course of time still increased, e.g. due to the economic crisis in 1920, to an eight hour day and a half, the change in the law meant a breakthrough. It indicated government interference in labor and employment, which before was considered ".. a contract between two individuals, where the government should stay out".
1929	**Sickness Act (Ziektewet)** which regulates the sickness benefits. Upon entry into force of the sickness act, employers had the choose: whether they could implement the statutory provisions applicable to public delegate Labor Councils or to the private business associations. With the additional requirement that business associations (bedrijfsverenigingen) were jointly formed by trade unions and employers' organizations.
1934	**Safety Act (revision**), with the legal obligation to establish **safety committees** in companies. In fact, the employed barely were involved in this Act due to the handling of the following definition of the employee: "... to protect an object and not an independent carrier of any responsibility."
1943	Establishment of the **Labour Foundation (Stichting van de Arbeid)**. The unions have set up a representation in official bodies that advise the government on economic matters.
1950	**Works Councils Act (WOR, Wet op de Ondernemingsraden)** The first objective was to WOR participation contributed to the functioning of the company. In 1971 this was extended for defending workers' interests.
1971	**Works Councils Act revision (WOR 1971, Wet op de Ondernemingsraden)** The revision broadened the field of the works council, with interests of employees, consultation for a number of strategic and economic issues and certain social policy issues including appointment and dismissal policies, pay systems and personnel evaluation.
1980	**Working Conditions Act, 1980** This law replaced the Safety Act of 1934. With as a major requirement that the policy to protect the worker takes permanently into account the most recent developments in technology and the state of science. The policy shifts to the pursuit of optimum working conditions.

1994	**Working Conditions Act, 1994** In the revision of the law, the obligation for firms to hire an external Occupational Health Service (Arbodienst) is introduced.
1998	**Working Conditions Act, 1998** The main change was to meet the needs of companies for tailor made working conditions. This need is accompanied by more accountability for employers and employees for the health, safety and absenteeism within companies, within the statutory frameworks.
2005	**Abolition of compulsory affiliation to Arbodienst / Occupational Health Service** From July 1 2005, organizations have the freedom of choice for supporting them in the organization of the working conditions and absenteeism. For safeguarding the quality of OSH, the internal prevention officer is installed.
2007	**OSH New Style (Arbo Nieuwe Stijl)** This approach replaces the Working Conditions Act of 1998. The major change can be summarized as followed: employers and employees have more opportunities and responsibility for a more customized policy concerning the working conditions. The government sets the frameworks, reflecting the aim of the Working Conditions as a 'window' or a 'framework' act. In the line with the new style, is the duty to establish with social partners an Arbocatalog, containing the agreement of employers and employees together on how they flesh out the statutory requirements on OSH.
2009	**Workability index (WAI)** September 2009, The Ministry of Social Affairs and Labour announces that it will introduce the Work Ability Index (WAI) itself. The WAI is a tool that provides insight into the working capacity of people and offers a view of sustainable employability. The use of the WAI is governed by 'Blik at Work' Foundation. Blik at Work is a partnership established in 2006. Government, employers and workers organizations, municipalities (VNG), re-integration organisation UWV WERKbedrijf, national client organisation (LCR), the association of occupational and re-integration services provides (Boaborea), the Netherlands Association of VET Colleges (MBO-Raad/FOTIN) and the association for career professionals (Noloc)

Sources:
For this brief history we gratefully used the thesis of Jan Popma (2003), information of the trade union FNV www.fnv.nl, employers' organisation VNO-NCW www.vno-ncw.nl, the SER (Social Economic Council, www.ser.nl) and the National Archives www.nationaalarchief.nl

Annex 3 OSH experts

1. Occupational physician / company doctor

This title is legally limited to registered medical experts specifically trained in the areas of employment and health. The two most prominent tasks of the occupational physician are:

1. Prevention and reduction of health damage related to work (working conditions)
2. Retention and recovery of work (re-integration)

The occupational physician is responsible for three of the mentioned obligatory OSH tasks of organizations: absenteeism support, PAGO/PMO (preventive medical check ups) and recruitment examinations. The other experts can also support on these items, but the occupational physician is the obligatory expert.

The occupational physicians are represented in the **NVAB: The Netherlands Society of Occupational Medicine.** Founded in 1946 as a separate section of the Association of Public Health and officially founded in 1953. Nowadays about 90% of the occupational physicians in The Netherlands, i.c. more than 2,000, are NVAB-member. One of NVAB's goals is enhancement of the scientific basis of occupational health practice and improvement of the professional quality of occupational physicians. One of the tools in a quality-improving strategy is the development, implementation and evaluation of evidence-based clinical practice guidelines.

2. Safety Officer

The expertise of safety officers can be distinguished in: work or occupational safety, external safety (incidents and emergencies), transport safety, consumer safety (outside the workplace) and patient safety (safety aspects related to medical treatments).

Occupational safety concerns all business activities that involve the risk of injury to persons or damage to objects. This concerns both the continuity of the organization and its processes, as well as the vitality, health and employability of the employees involved.

NVVK: The Dutch Society for Safety Engineering

The NVVK was founded in 1947 and is home to about 1,900 diverse professions on safety, such as work safety, but also consumer safety, safety in transport. The NVVK is an active participant in the development of safety guidelines and safety laws and regulations.

3. Occupational hygienist

Occupational Hygiene focuses on recognizing, evaluating and controlling particular physical, chemical and biological factors that may harm the health of workers. After assessments of work situations, occupational hygienists advise on appropriate action in relation to aspects as :

- exposure, respiratory or skin contact with harmful substances (dust, gas, vapor) and biological agents (microbes: bacteria, fungi, yeast, viruses);

- exposure to harmful noise levels;
- climate problems, related to lighting, noise levels, temperature
- exposure to electromagnetic fields (power lines, UMTS);
- exposure to body vibration or hand-arm vibration.

NVvA: The Dutch Occupational Hygiene Society

The NVvA was founded in 1983 and now has almost 500 members. The aim of the society is:

- To promote and to stimulate the quality of the profession of the occupational hygienist.
- To promote the science of occupational hygiene.
- To raise awareness of the speciality of occupational hygiene.

4. Work & Organizational Professional

This expert is the most remarkable, comparing to other European countries where no such expertise is included in the law concerning working conditions. The core expertise of this professional can be described as follows:

- Optimization of work content and organization of work;
- Development and implementation of OSH systems;
- Development, improvement and implementation of policy on absenteeism;

This professional supports employers in employability and productivity of employees. The **BA&O, the professional Association for Work & Organization Professionals** is the youngest of the four associations, founded in 1995.

5. Other expertise

Other specialists, not mentioned specifically in the act and yet mostly also in charge on work and health in organizations, are the occupational nurse and ergonomist, and more recently the psychologist work and health.

6. Internal Prevention Officer

Besides (external) experts, in the company the responsibility for health and safety is included in functions of employees. In the Netherlands, it is obliged for organizations with more than 25 employees to have at least one internal Prevention Officer (Preventiemedewerker).
In many organizations, the existing health and safety coordinator fulfills the role of the prevention officer. In small enterprise with less than 25 workers, the employer has the role of prevention officer.

The prevention officer supports employees in the daily safety and health. The officer has knowledge of the risks within the company The prevention officer has three statutory duties:

1. the (co) preparation and implementation of the risk inventory (RI&E);
2. advisement of and co-operation with the works council / staff representatives in taking measures for good working conditions;
3. Implementation of measures on OSH.

7. Professional Guidelines and standards

Professional guidelines are systematically developed statements designed to assist professional decisions about appropriate health care for specific occupational circumstances. The basis of practice guidelines is[7]:

- Scientific evidence (Evidence Based Medicine, systematic reviews, Practice Based Evidence, circumstantional evidence);
- Professional opinions and ethical principles;
- Consensus (peer group);
- Practical experience.

The recommendations in the guidelines are based upon the best available scientific evidence and further considerations: costs, side effects, patient perspectives, organizational aspects i.e.
The guidelines on work and health, are most strongly developed by occupational physicians with for example guidelines on:

- Psychological problems;
- Musculoskeletal complaints;
- Respiratory disorders;
- Dermis;
- Senses;
- Infectious diseases.

Recently, there are becoming guidelines on these topics for other experts such as the guideline on work and psychological complaints for psychologists (NIP/LVE, 2005).

Besides guidelines the OSH experts work with:

- professional codes (beroepscode);
- standards, like the ISO and the standards of general practitioners (GP);
- practical guides based on professional consensus (STECR werkwijzers);

[7] With minor change of source: NVAB, Netherlands Society of Occupational Medicine http://nvab.artsennet.nl

- guidelines concerning practical interventions:
    - such as the COTAN for psychological testing and
    - the standards concerning safety at work.

Annex 4 Summary of the changes of social security laws

The table provides insight in the main changes of social security over time. The changing of the intention over time – keeping employees capable of work - is also seen in the names of laws and regulations. Was it formerly the Disability Act WAO, in 2005 the Work and Income according to Labour Capacity Act (WIA) is active. The question marks in the last two cells, refer to what will be the future names of current laws.

summary of the changes of social security laws			
Past: Welfare state		**Now: Active and Participative state**	
AWB	Social Assistance Act [Algemene Bijstandswet]	WWB	Work and Social Assistance Act [Wet Werk en Bijstand]
WAO	Invalidity Benefit Act [Wet op de arbeidsongeschiktheidsregeling]	Wet WIA	Work and Income according to Labour Capacity Act [Wet Werk en Inkomen naar Arbeidsvermogen]
	Invalidity compensation [WAO-uitkering]	WGA-uitkering	Work retention rule for partly capable for working [Werkhervattingsregeling gedeeltelijk arbeidsgeschikten]
Wajong	Invalidity Benefit Act for Young disabled [Wet op de arbeidsongeschiktheid voor jongehandicapten]	Wet Wajong	Law Work and Work involvement Young Disabled [Wet Werk en arbeidsinschakeling jonggehandicapten]
ZW	Sickness Benefits Act [Ziektewet]	?	?

Source: Evers H (2009)

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- Netherlands Society of Occupational Medicine NVAB. Centre of Excellence. Kees van Vliet, André Weel
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Translation

For the translation of terminology, we used IATE. IATE is the abbreviation of: Inter-Active Terminology for Europe and functions as the EU inter-institutional terminology database. IATE has been used in the EU institutions and agencies since summer 2004 for the collection, dissemination and shared management of EU-specific terminology .

http://iate.europa.eu