The Netherlands: the three rings of the prevention market and market controls

Preventive services (known as *Arbodiensten*) are mainly external provision. They have expanded rapidly and there is now coverage of almost all workers (98% in 2001, according to Ministry for Work figures). The number of specialists working in these services has also risen rapidly, as the table below shows.

	1994	1997	2000
Total workers (full-time equivalents)	5421	7291	9424
Doctors (occupational medicine and GPs)	1486	1846	2244
Other basic specialities*	369	695	832
Working conditions advisors**	-	251	359
Paramedical and emergency first aid staff	1286	1291	1650
Absence reporters	-	515	527
Clerical staff	1169	1785	2796

Source: Dutch Ministry for Work 2002[1]

* The other statutorily-prescribed basic specialists are in safety, industrial hygiene and work organization.
** Working conditions advisers include a range of expertise like ergonomics, industry specialists, company social workers.

About half of all specialists (47%) come from the medical or paramedical professions, 15% are miscellaneous specialists providing consultancy on working conditions, while clerical and other staff make up about 38% of the total. The number of occupational safety and health specialists employed by preventive services per 100 000 workers is 93 (figures for 2000). The average amount spent on preventive services per worker has also risen - from 92 euros in 1995 to 127 euros in 2001.

The picture could not look rosier. And yet there is growing unease among prevention professionals and workers alike. The gnawing doubt is whether these services are really preventive services trying to improve working conditions in order to protect workers' health and well-being. For the past fifteen-odd years, a debate has been rolling in Holland on the very large numbers of employees off work due to incapacity or invalided out of the labour market entirely[2]. The main thrust of government policies on occupational health has been to ease the cost pressures this placed on the social security system. Various options have been tried: forcing employers to shoulder part of the costs, pooling the cost burden through insurance systems, introducing financial incentives to cut absenteeism, getting prevention professionals to give it a priority focus. By and large, none of these policies has delivered the goods. Sickness absence and work disability levels remain very high. But at the same time, prevention activity has taken a series of hard knocks. The confidence that workers should have in preventive services has been undermined by the medical checks they carry out on workers who are on disability leave. Action to get sick and injured workers back to work quickly has taken precedence over improvements to collective working conditions. This deflection of the system has been made worse by the failure to set specific regulatory criteria for the activity and control of preventive services. Activities are largely specified by employers themselves on the basis of their contract with a preventive service. Quality control of services is privatized and based on certification procedures in which neither trade unions nor the labour inspectorate have a say. Conventional quality certification systems work at cross-purposes. While certification can have a positive impact on some things, like ensuring that the service has the necessary aptitudes or that work procedures have been clearly defined, it falls down by taking customer satisfaction as the main consideration. The reason is that the idea of a "customer" for preventive services does not really apply to health and safety provision. A set of contradictory and often conflicting demands are at work: the employer's demands driven by his short-term goals, workers' and their unions' demands, a more diffuse social demand about the priorities of workplace health policies. Third party certification is apt to give priority to employers' demands, and that detracts from the professional independence of prevention experts. That is the finding of Dutch researchers: "the delicate balance between client (mostly employers') demands and professional responsibility is disturbed by the unconditional dominant role of the clients in some quality assurance systems. In our opinion, the OHS-client relationship should be terminated when a persistent substantial difference in visions comes in serious conflict with professional integrity"[3].

The wording of the final sentence reflects the difficulty of achieving public control (by the public authorities) and social control (by trade unions) in the Dutch system by which to resolve disputes other than by simply walking away from contracts.

The under-reporting of occupational diseases illustrates this deflection in the system that puts the "customer" (firm)'s interests above those of a workplace health policy. In 2000, just under half of preventive service doctors had reported at least one occupational disease, and in 2001, both the number of

[1] Data from: Ministerie van Sociale Zaken en Werkgelegenheid, *Arbobalans 2002. Arbeidsrisico's, effecten en maatregelen in Nederland*, The Hague, 2002.
[2] See Geurts, Kompier & Gründemann, "The Dutch disease? Sickness absence and work disability in the Netherlands", *International Social Security Review*, vol. 53, no. 4, 2000, pp. 79-103.
[3] F. van Dijk, C. Hulshof, J. Verbeek, Good occupational health practice : concepts and criteria : Finnish Institute of Occupational Health, *Good Occupational Health Practice and Evaluation of Occupational Health Services*, Helsinki, 1999, pp. 22-23.

reporting doctors and the total number of reported diseases was even slightly lower. A survey was done in 2000 into the reasons preventive service doctors gave for not going ahead with procedures to get occupational diseases recognized[4]. Just under half of responding doctors said it would take up too much of their time (359 doctors out of 829 - 43.3%)[5]. This was the most common reply ahead of lack of information on cause (41%). In just under a quarter of cases (22.9%), it was to avoid legal proceedings against the employer. Around a fifth of doctors claimed no familiarity with the reporting criteria (22.9%), or that the preventive service in which the doctor was working did not usually report occupational diseases (19.9%)[6]. In the Dutch system, victims are not directly disadvantaged in that they do not lose out on benefit from the failure to report an occupational disease, because the social security system makes no difference between incapacity for work due to ordinary illness and an occupational disease. From a prevention policy standpoint, by contrast, under-reporting of diseases to a large extent conceals workplace health problems, which can only distort the assessment of the situation and priority setting. It says much that to assess the scale of work-related skin diseases, a surveillance system based on notifications by dermatologists had to be set up, and they report a higher number of cases than preventive service doctors[7].

The public authorities' abdication of responsibility is almost certainly made worse in the Netherlands by the features of the markets created. The preventive services market is clearly developing along oligopolistic lines. A small number of external services enjoy a dominant position: 5 services cover close to 90% of firms. The control market (through certification procedures) is moving towards even greater concentration: two certification companies (Lloyd's and DNV) hold a dominant position. That goes some way to explain the contrast between the development of a flourishing market in which quality is certified by minutely-detailed procedures and the growing dissatisfaction among those who actually use the system. That is compounded by the growing number of firms opting for third-party certifications, either of OSH personnel or the existence of an occupational health management system. Personnel certification covers a wide range of areas: aptitudes linked to prevention activities, like first aid; aptitudes regarding high-risk jobs like fork-lift truck driving, or aptitudes for working in jobs that involve hazardous exposures for workers or the environment (e.g.: certificate for use of pesticides). Certification of management systems are generally based on ISO standards. There is a specific certification for subcontractor firms - the VCA (Safety Certificate for Subcontractors). It is estimated that 37% of all Dutch firms already have one or more certificates. The link with subcontracting is clear to be seen in the particularly high percentages for the building industry, where 64% of firms have at least one certificate. The result of such approaches is often to allow customer firms to abdicate their responsibilities where subcontracting is involved. They simply check whether the firm has a certificate, not what it involves in terms of the actual quality of prevention and, especially, without assessing how far the conditions of subcontracting they are offering or imposing are consistent with occupational health. To date, the Netherlands is the only European country to have set up a complaints office for workers to submit their grievances against preventive services. And there appears to be no shortage of complaints!

The conclusion drawn by the Dutch research is disturbing: "in practice, the Dutch *Arbodiensten* hardly contribute to prevention at all, but are medical centres specialized in individual care and control. Over 90% of the contracts concluded with the OHS services consist either entirely or for their major part of sickness absenteeism guidance. The medical problems of individual workers are hardly ever converted into a preventive approach, aiming to improve working conditions in the workplace. The added value of the OHS services as compared to general practitioners is deemed to be very limited"[8]. ■

[4] Nederlands Centrum voor Beroepsziekten (NCB), *Signaleringsrapport Beroepsziekten 2001*, Amsterdam, 2001.
[5] More than one answer could be given, hence the total percentage above 100%.
[6] The *arbodiensten* have had a discretion to report occupational diseases since 1997; they have had a duty to do so since November 1999.
[7] NCB, *Signaleringsrapport Beroepsziekten 2002*, Amsterdam, 2002, pp. 31-37.
[8] J. Popma, M. Schaapman, T. Wilthagen, The Netherlands: Implementation within Wider Regulation Reform : D. Walters (ed.), *Regulating Health and Safety Management in European Union. A Study of the Dynamics of Change*, Bruxelles, P.I.E.-Peter Lang, 2002, p. 204.