



European Foundation for the Improvement of Living and Working Conditions

Working conditions remain stable in the Netherlands

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Wyattville Road, Loughlinstown, Dublin 18, Ireland. - Tel: (+353 1) 204 31 00 - Fax: 282 42 09 / 282 64 56
e-mail: information@eurofound.europa.eu - website: www.eurofound.europa.eu

Despite significant changes in the national questionnaires on work and health, the quality of work as well as health complaints in the Netherlands appear to be relatively stable. Pace of work seems to be on the increase again and more people are working in excess of their contractual hours. Notwithstanding changes in disability legislation, psychological disorders remain a factor in dropping out of employment. Overall, absenteeism has been decreasing recently although work-related illnesses tend to result in longer spells of absence.

Introduction

This report will discuss the following trends in working conditions and health:

- exposure to psychosocial risk factors, such as a high pace of work, emotionally demanding work and workplace violence;
- exposure to physical risk factors, such as noise, physically dangerous work and dangerous substances;
- exposure to ergonomic risk factors, such as heavy physical work, uncomfortable postures, repetitive movements and work with VDUs (visual display units);
- working hours, including flexible working hours, working non-standard hours, and combining work and family life;
- self-reported health outcomes and work-related health outcomes, including the drop out from work due to absence and disability.

Statistical sources

Previous Dutch survey data reports ([NL0403SR01](#), [NL0601SR01](#)) referred to a variety of statistical sources; however, the majority of those resources have not been updated since the last report in 2006. Therefore, this report mainly relies on results from the Netherlands Working Conditions Survey (*Nationale Enquête Arbeidsomstandigheden*, [NEA](#)) carried out in 2003, 2005 and 2006.

In addition, this study refers to information from the national disability register, which contains data on disability inflow, outflow and volume by diagnostic category; the Social Security Administration (*Uitvoeringsinstituut Werknemers Verzekering*, [UWV](#)) maintains this register. Finally, the data of the NEA are compared with some results of the Permanent Quality of Life Survey (*Permanent Onderzoek Leefsituatie*, POLS). This study is conducted by Statistics Netherlands ([Centraal Bureau voor de Statistiek](#), [CBS](#)), and contained a module on working conditions and health which was presented to a cross-section of the Dutch workforce between 1977 and 2003.

Details on the methodology of these statistical sources are available in the annex at the end of this report.

Trends in working conditions

In the last decades, a shift has occurred in the nature of jobs performed. Whereas traditionally many tasks were characterised by exposure to physically heavy work, nowadays more jobs are of a sedentary office nature, associated with repetitive movements and greater exposure to psychosocial risk factors ([NL0411NU06](#)). The previous survey data reports for the Netherlands have shown that working conditions have changed accordingly. Exposure to physically heavy

work has decreased, while exposure to psychosocial risk factors and exposure to risk factors related to desk work initially increased but have levelled off since 1997.

This report will discuss whether this pattern continues to exist in the period 2003–2006, a time of both economic decline, from 2001 to 2004, as well as of economic growth, from 2004 onwards. It also focuses on the extent to which employees find these working conditions problematic, as reflected in the extent to which they find it necessary that measures are taken to manage specific types of risk.

Psychosocial risk factors

Exposure to high work pressure has increased slightly from 31% to almost 34% in the 2003–2006 period, while exposure to emotionally demanding work has remained relatively stable at about 7%–8.5% (see Figure 1 below). Men experience high work pressure more often, at 34.9% for men compared with 32.5% for women, while women are more often exposed to emotionally demanding work, at 9.1% for women compared with 7.9% for men. The highest work pressure is experienced in the education sector, at 40.3%, while emotionally demanding work is common in the healthcare sector, at 20.2%.

Exposure to workplace violence has decreased. This is particularly the case for violence from customers over the past 12 months, which declined from 30% in 2003 to 26% in 2006. Tables 1–3 show that intimidation is the most common form of workplace violence, followed by sexual harassment and physical violence. Women are more often troubled than men are by workplace violence from customers, while workplace violence from colleagues is more common among men than women (Table 1). The manufacturing and hotels and restaurants sectors report the highest prevalence of workplace violence from colleagues (Table 2), whereas workplace violence from customers is most prevalent in the healthcare sector (Table 3).

Table 1: Workplace violence, by sex, 2006 (%)

This table outlines the proportion of women and men experiencing sexual harassment, intimidation and physical violence in the workplace from colleagues or customers.

	Women	Men	Total
Workplace violence from colleagues	13.7	17.6	15.8
- Sexual harassment	4.8	1.7	3.1
- Intimidation	11.4	16.6	14.2
- Physical violence	0.5	1.1	0.8
Workplace violence from customers	32.9	20.9	26.4
- Sexual harassment	12.1	3.1	7.2
- Intimidation	28.1	19.5	23.5
- Physical violence	8.3	4.7	6.3

Source: NEA 2006

Table 2: Workplace violence from colleagues, by sector, 2006 (%)

This table outlines the sectoral distribution of experiences of sexual harassment, intimidation and physical violence in the workplace from colleagues.

	Workplace violence from colleagues	Forms of workplace violence		
		Sexual harassment	Intimidation	Physical violence
Agriculture	10.7	1.9	10.0	0.6
Manufacturing	20.0	3.0	18.5	1.2
Construction	13.2	0.8	12.6	0.9
Wholesale and retail trade	15.1	2.4	13.8	0.8
Hotels and restaurants	20.0	6.5	15.4	2.8
Transport, storage and communications	19.1	3.6	17.4	0.5
Financial services	16.4	3.5	14.6	0.4
Business services	14.1	3.2	12.5	1.1
Public administration	18.6	4.8	16.2	0.8
Education	14.6	2.7	13.4	0.5
Healthcare and social work	12.8	2.9	11.3	0.4
Cultural activities	15.5	3.7	13.9	1.0

Source: NEA 2006

Table 3: Workplace violence from customers, by sector, 2006 (%)

This table outlines the sectoral distribution of experiences of sexual harassment, intimidation and physical violence in the workplace from customers.

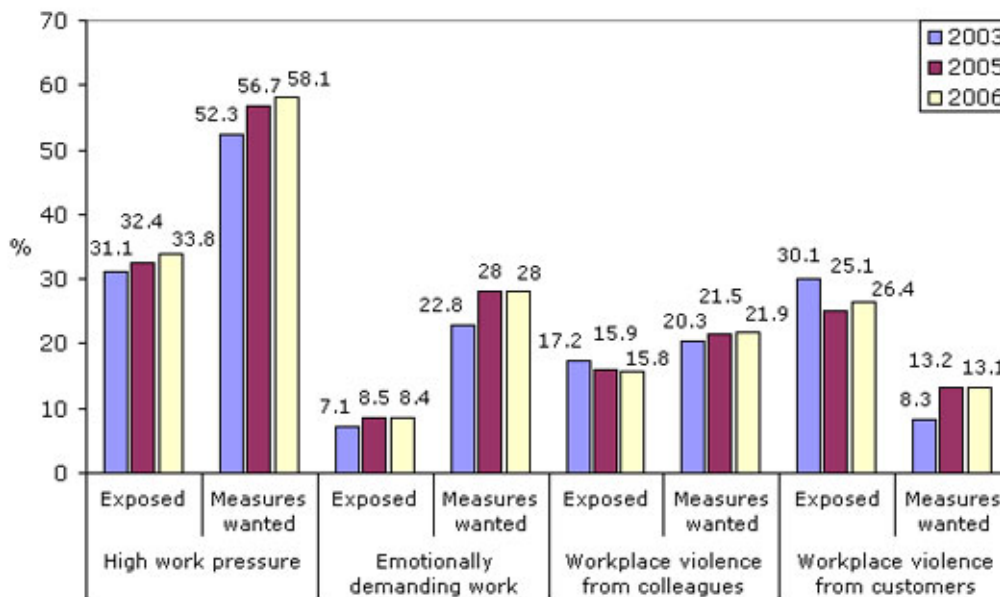
	Workplace violence from customers	Forms of workplace violence		
		Sexual harassment	Intimidation	Physical violence
Agriculture	8.2	3.4	6.0	1.3
Manufacturing	9.8	2.0	8.8	0.8
Construction	11.5	1.4	10.7	1.0
Wholesale and retail trade	28.9	6.8	26.7	2.7
Hotels and restaurants	29.9	14.7	25.6	5.2
Transport, storage and communications	27.4	5.3	25.8	5.4

	Workplace violence from customers	Forms of workplace violence		
		Sexual harassment	Intimidation	Physical violence
Financial services	21.6	2.0	20.9	0.5
Business services	18.6	4.2	16.7	2.4
Public administration	32.7	5.4	30.7	10.4
Education	30.0	4.4	28.4	6.2
Healthcare and social work	47.9	20.2	39.0	21.0
Cultural activities	23.2	5.3	21.4	3.2

Source: NEA 2006

The percentage of employees who find it necessary that measures are taken is generally higher than the proportion of employees who are exposed (Figure 1). Some 58% of the employees surveyed in 2006 believe that measures should be taken to alleviate high work pressure, an increase of almost six percentage points since 2003. It is notable that, although exposure to violence has declined over the 2003–2006 period, the proportion of employees who want measures against violence has increased during this same period.

Figure 1: Exposure to psychosocial risk factors (%)



Exposure to psychosocial risk factors (%)

Source: NEA 2003–2006

Physical risk factors

Exposure to physical risk factors (see Figure 2 below) continued to decrease over the 2003–2006 period. Exposure to noise ([NL06070291](#)) decreased from 34% in 2003 to just under 31% in 2006. The decline in exposure to the inhalation of dangerous substances is particularly notable, from 15% in 2003 to 10% in 2006. Clear gender and sectoral differences emerge (Table 4). Men are more often exposed to physical risk factors than women are, except for skin contact with dangerous substances. Exposure to physical risk factors is high in the construction, agricultural and manufacturing sectors – with the exception of exposure to dangerous substances on the skin, which is high in hotels and restaurants, at 53.8%.

Table 4: Exposure to physical risk factors, by sex and sector, 2006 (%)

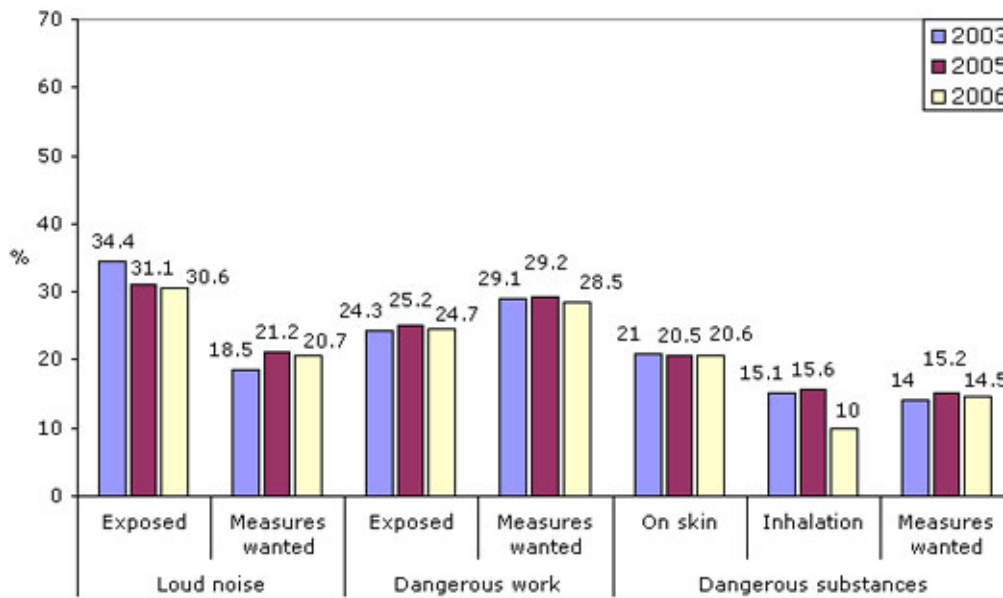
This table shows the % exposure of women and men to loud noise at work, dangerous work, dangerous substances on the skin and by inhalation. These physical risk factors are also outlined according to sectoral distribution.

	Loud noise	Dangerous work	Dangerous substances on skin	Inhaling dangerous substances
Sex				
Women	19.7	12.9	26.2	3.2
Men	39.7	34.5	15.8	15.7
Sector				
Agriculture	51.0	47.8	17.3	11.5
Manufacturing	51.6	35.9	21.8	19.5
Construction	63.2	59.8	20.9	30.0
Wholesale and retail trade	25.7	21.7	19.5	11.4
Hotels and restaurants	46.0	31.2	53.8	6.3
Transport, storage and communications	38.4	32.7	5.7	19.2
Financial services	14.5	1.9	1.1	1.2
Business services	18.7	14.3	11.6	6.2
Public administration	20.3	23.8	4.4	4.5
Education	31.1	7.2	8.4	2.1
Healthcare and social work	16.9	22.7	47.1	2.1
Cultural activities	31.9	21.1	16.4	9.2
Total	30.6	24.7	20.6	10.0

Source: NEA 2006

The extent to which employees find it necessary that measures should be taken to reduce the exposure to these physical risk factors has remained stable over the time period in question, and has even slightly increased in relation to measures against loud noise (Figure 2).

Figure 2: Exposure to physical risk factors (%)



Exposure to physical risk factors (%)

Source: NEA 2003–2006

Ergonomic risk factors

When looking at ergonomic risk factors, it appears that exposure to heavy physical risks has remained stable, while working in uncomfortable postures is decreasing. However, exposure to risk factors associated with desk work has increased, with the exception of repetitive movements. Women are slightly more likely to work with visual display units (VDUs) and experience repetitive movements, but overall men generally have higher physical exposure (Table 5). Exposure is highest in the construction sector, with the exception of VDU work, which is very high in financial services at 70.6%. No clear change emerges in the extent to which employees find it necessary that measures are taken (see Figure 3 below).

Table 5: Exposure to ergonomic risk factors, by sex and sector, 2006 (%)

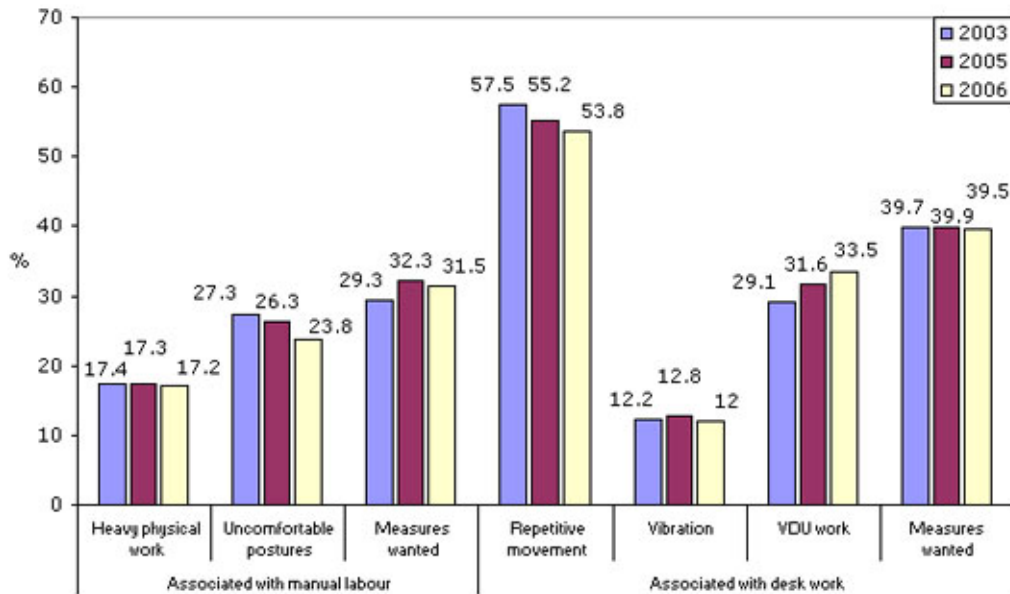
This table shows the % exposure of women and men to heavy physical work, uncomfortable postures, repetitive movements, vibration and working with VDUs. These ergonomic risk factors are also outlined according to sectoral distribution.

	Heavy physical work	Uncomfortable postures	Repetitive movements	Vibration	VDU work
Sex					
Women	11.2	22.2	53.9	2.7	34.8
Men	22.2	25.2	53.6	19.8	32.4
Sector					

	Heavy physical work	Uncomfortable postures	Repetitive movements	Vibration	VDU work
Agriculture	32.7	43.4	72.4	38.4	9.2
Manufacturing	22.2	27.9	56.8	21.4	31.9
Construction	42.5	41.3	63.2	43.2	21.4
Wholesale and retail trade	21.6	25.9	57.6	14.4	26.9
Hotels and restaurants	15.2	28.7	62.4	6.5	11.8
Transport, storage and communications	23.5	23.3	62.4	20.4	31.6
Financial services	0.9	14.6	66.0	0.3	70.6
Business services	7.7	20.1	62.7	6.1	55.4
Public administration	6.2	15.2	54.8	4.0	50.0
Education	2.6	13.8	30.3	1.5	21.7
Healthcare and social work	21.9	24.1	36.1	2.5	17.8
Cultural activities	11.7	24.6	53.1	13.1	34.1
Total	17.2	23.9	53.8	12.0	33.5

Source: NEA 2006

Figure 3: Exposure to ergonomic risk factors (%)



Exposure to ergonomic risk factors (%)

Source: NEA 2003–2006

Working time

According to the NEA, employees worked a stable 31 hours (4.3 days) a week in 2003–2006 (Table 6). However, both the proportion of employees who report working overtime and the average number of overtime hours worked appear to be slightly on the increase. Furthermore, the number of hours that employees work at home ([NL0704039I](#)) appears to be increasing as well. The percentage of employees who work in shifts is stable at just below 15%. Meanwhile, the proportion of employees who work in the evening or at night or at the weekend is substantially higher, at over 50%.

In 2005, 9.6% of Dutch employees considered that they neglected their family because of their work, while 2% believed that they neglected their work because of their family. However, since this was not measured in 2006, it is not possible to discern possible trends. The proportion of workers who find it difficult to combine work and family life – that is, they are not allowed sufficient flexibility or room to manoeuvre to balance them – remains stable at about 14% in 2005 and 2006.

Table 6: Working hours and scope for balancing work and home life

This table outlines the average working hours and days per week, the average amount of overtime, shift, night and weekend work, work done at home and work-life balance.

Working time	2003	2005	2006
Contractual working hours per week	31.6	31.2	31.3
Working days per week	4.3	4.3	4.3
Working overtime (% yes)	-	27.6	28.6
Overtime (hours per week)	3.9	5.1	5.4
Contractual work performed at home (hours per week)	1.1	1.4	1.5
Shift work (% yes, sometimes)	-	14.6	14.6
Working evenings/nights (% yes, sometimes)	-	51.6	51.8
Working weekends (% yes, sometimes)	-	53.8	54.3
Difficulty balancing work and home life (% not having enough scope to balance them)		13.6	14.2

Note: '-' means that this information is not available for 2003.

Source: NEA 2003–2006

General and work-related health

The vast majority of employees, at 90%, consider their health to be good or even excellent (Table 7). This proportion remains stable over the years (Table 8). However, the percentage of employees who reported greatly needing time to recover after work increased from 2003 to 2005, as did the proportion of workers suffering repetitive strain injury (RSI) complaints in the previous 12 months. Between 2005 and 2006, the need for recovery time after work remained about stable, while RSI complaints showed a decline.

Little difference in general health emerges between men and women or between sectors, but women cite a high need for recovery time after work and experience RSI complaints more often than men do. Workers in the education sector most often experience a high need for recovery time, which correlates with the levels of exposure to psychosocial risks in this sector.

Table 7: Health outcomes, by sex and sector, 2006

This table outlines the proportion of men and women reporting good or excellent health, the % requiring time to recover after work and the % reporting RSI complaints. The sectoral data are also shown.

	Health (% good/excellent)	High need for recovery time after work (% yes)	RSI complaints (% yes)
Sex			
Women	89.6	29.8	29.6
Men	89.9	27.8	23.4

	Health (% good/excellent)	High need for recovery time after work (% yes)	RSI complaints (% yes)
Sector			
Agriculture	92.1	18.5	27.5
Manufacturing	87.9	28.3	29.2
Construction	88.9	26.9	27.2
Wholesale and retail trade	89.9	26.4	26.5
Hotels and restaurants	89.5	28.8	25.9
Transport, storage and communications	89.5	29.9	27.4
Financial services	91.6	29.3	24.1
Business services	90.2	28.4	24.8
Public administration	91.0	26.3	24.1
Education	89.1	36.5	22.2
Healthcare and social work	90.9	29.8	27.4
Cultural activities	89.2	30.7	25.9
Total	89.8	28.7	26.2

Source: NEA 2006

Table 8: Health outcomes, 2003–2006

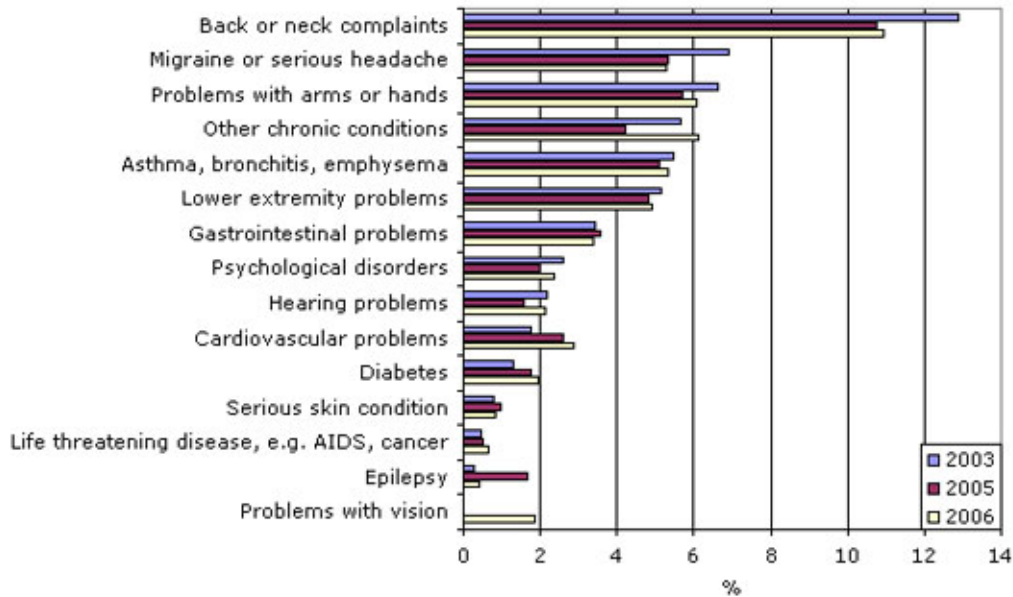
This table shows the trends in health, need for recovery time after work and RSI complaints between 2003 and 2006.

	2003	2005	2006
Health (% good/excellent)	91.3	89.9	89.8
High need for recovery time (% yes)	26.5	29.0	28.7
RSI complaints (% yes)	25.6	27.0	26.2

Source: NEA 2003–2006

Figure 4 shows the proportion of employees with various chronic illness conditions: in both 2003 and 2006, the overall share stood at 36% and in 2005 it dropped to 34%. It appears that physical problems, such as back and neck complaints, and to a lesser extent arm and hand problems, have declined from 2003 to 2005–2006. However, although the prevalence of chronic psychological disorders decreased slightly from 2.6% in 2003 to 2% in 2005, these problems escalated again to 2.4% in 2006 (Figure 4).

Figure 4: Chronic illnesses (%)



Chronic illnesses (%)

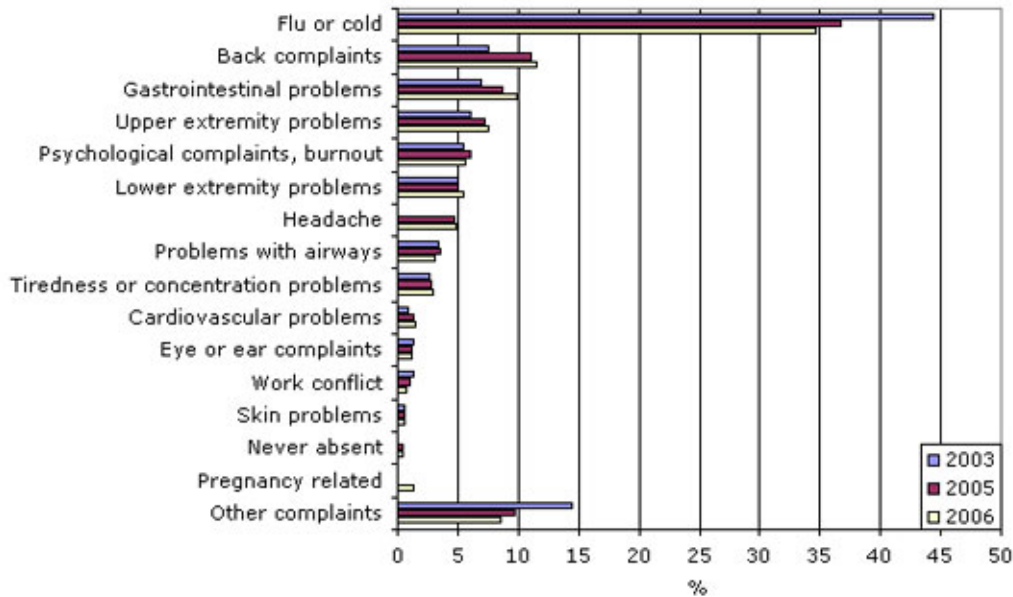
Source: NEA 2003–2006

Absenteeism from work

Absenteeism figures in the Netherlands are rather low, and have declined from 5.5% in 2002 to 4% in 2004, according to CBS data. The economic recession in the Netherlands was assumed to be among the reasons for this reduction.

The most prevalent diagnostic cause of absenteeism was, and remains, the flu or a cold. However, complaints related to heavy physical work, such as back complaints, appear to be on the increase. This is also found for neck, shoulder, arm and hand complaints, which are associated with office work. No clear change emerged in the prevalence of absence due to complaints related to psychological problems (Figure 5).

Figure 5: Most prevalent diagnostic reasons for absenteeism (%)

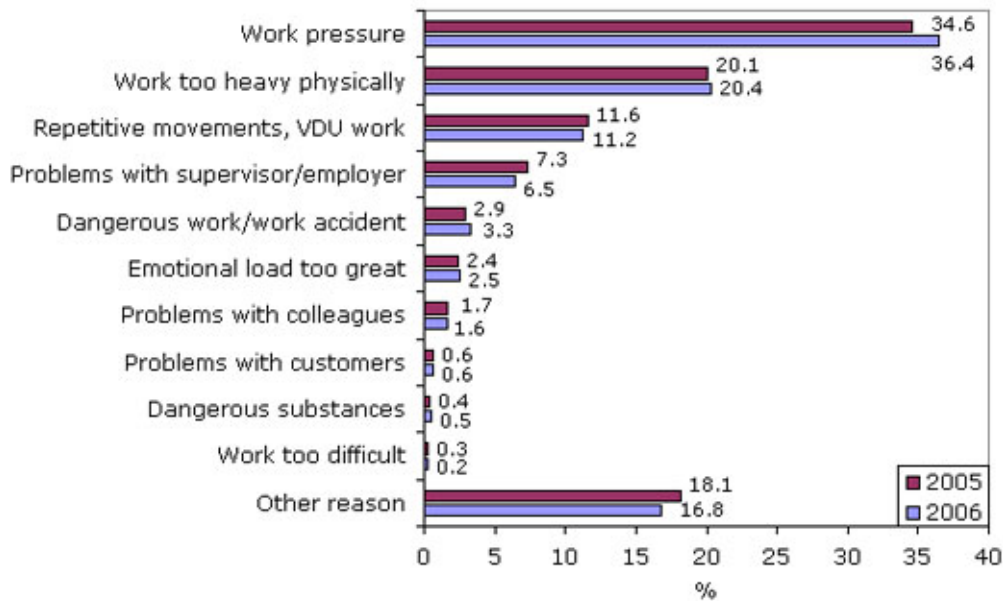


Most prevalent diagnostic reasons for absenteeism (%)

Source: NEA 2003–2006

When employees indicate that the absenteeism is work related this is usually due to work pressure or because the work is physically too strenuous: about 35% of workers taking work-related sick leave cited the former reason, while 20% mentioned the latter (see also [NL0607NU04](#)). Other often mentioned reasons are repetitive work or computer work and problems with the supervisor or employer (Figure 6). However, when employees are absent for a longer period, the reasons for taking time off are different. The main reasons for longer spells of work-related absence are: psychological health problems, reported by 25% of workers absent for more than 13 weeks; back disorders, cited by 19% of this group; and neck, shoulder and arm problems, recorded by 13% of those absent up to 13 weeks..

Figure 6: Reasons for work-related absenteeism (%)



Reasons for work-related absenteeism (%)

Source: NEA 2003–2006

Changes in disability benefit regulations

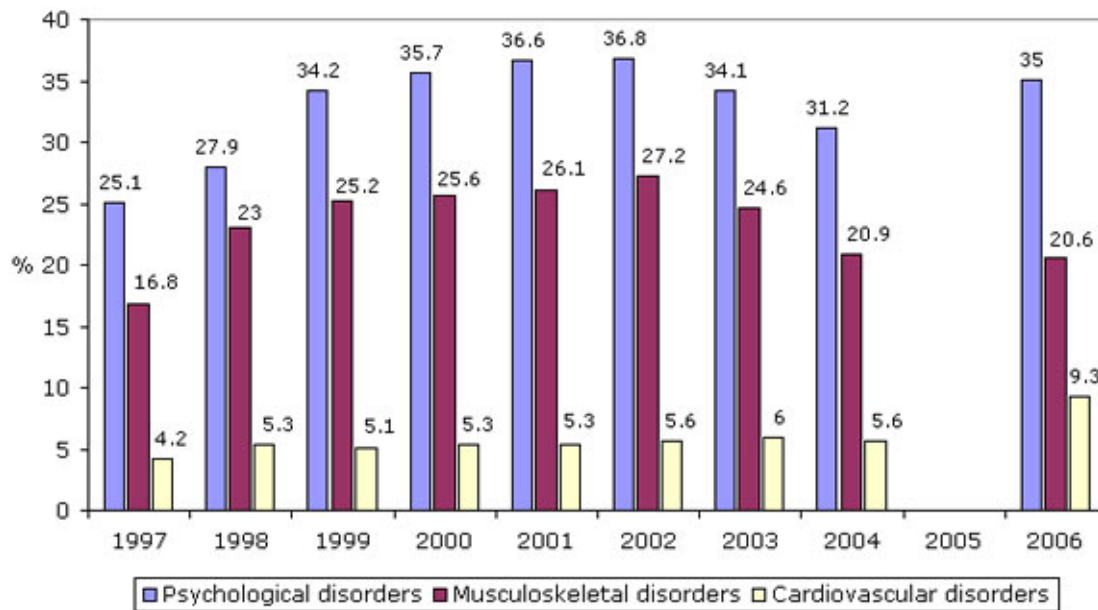
Since 2004, regulations regarding work disability benefits have been amended. The biggest changes are:

- the introduction in 2004 of a two-year (instead of one year) waiting period before the disability benefit assessment takes place, leaving the employer responsible for the reimbursement of the pay loss due to the absence;
- a shift of focus in 2006 from what an employee cannot do to what he or she can do in the decision to grant the disability benefit. This results in a higher benefit for those who are assessed as being permanently and fully disabled for work, and no or less money for those assessed as being partly and non-permanently disabled for work.

These changes were partly initiated as a result of the high inflow of employees into the disability benefit pension system, as well as the relatively high inflow of employees with psychological problems. Figure 7 shows that in the past decade the most prevalent diagnostic category for work disability remains – despite the above changes – psychological disorders, with musculoskeletal complaints in second place.

A peak in disability inflow was reached just after the turn of the century. In 2002, the absolute inflow of employees into the benefit system started to decline. This trend continued until 2006, although the results for that year are probably blurred due to the changes in regulations on entry into this system. Despite a total reduction in disability inflow due to the new regulations, it appears that the relative share of psychological and cardiovascular disorders has increased (Figure 7).

Figure 7: Three main diagnostic categories for registering for work disability pension (%)



Three main diagnostic categories for registering for work disability pension (%)

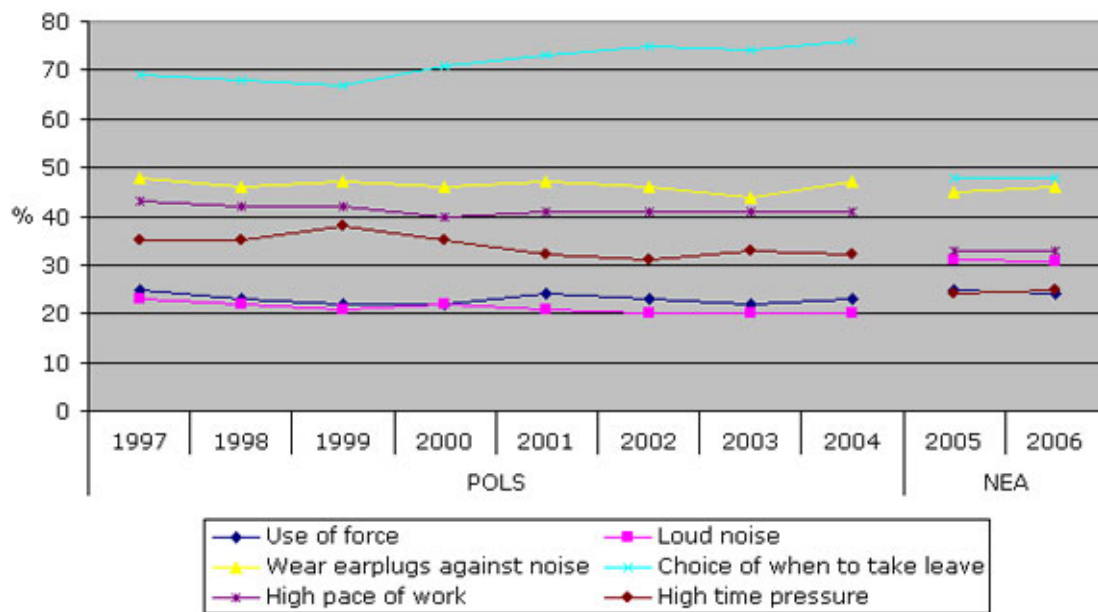
Note: The period 1993–2004 reflects the old regulations and 2006 reflects the new regulations. No data are presented for 2005 because in January 2004 the waiting period for the assessment on disability benefits changed from one to two years. Because of this, hardly any inflow into the system took place in 2005.

Source: UWV, 1997–2006

Commentary

The surveys on work and health in the Netherlands underwent a major change after 2002. While the previous survey data reports were mainly based on the POLS statistics, the latter have ceased to exist since the last report. However, a few questions that featured in the POLS, as well as several major concepts, have also been asked in the NEA, which can be considered the follow-up questionnaire to the POLS regarding quality of work and health. Although both surveys use a different methodology – comprising a written questionnaire for the NEA while the POLS is interview-based – it is interesting to look at the development of the indicators using the same questioning over the years. Figure 8 reveals that the proportion of workers who report that they are able to choose when they take leave is much lower according to the NEA than according to the POLS. For the remaining factors, the level of exposure according to the NEA more closely resembles that of the POLS.

Figure 8: Trends of POLS and NEA surveys regarding certain work-related factors (%)



Trends of POLS and NEA surveys regarding certain work-related factors (%)

Source: CBS, 1997–2004 and NEA, 2005–2006

Figure 8 illustrates that it is not possible to simply interpret NEA answers to POLS questions as being comparable. The NEA suggests a smaller range than the POLS. Furthermore, the ranking order of percentages of employees indicating that they perceive a specific risk is not the same between the two surveys, despite the fact that they appear to identify the same risk concept. However, it does seem that the trend in risk indicators for NEA and POLS is comparable: overall, the quality of work in the Netherlands appears to be rather stable.

The NEA appears to be a good reflection of the Dutch workforce and, in restricting the analysis to NEA data, it may be concluded that little change has arisen in the quality of work in the Netherlands. Nonetheless, some new trends may be developing. Since 2005, the pace of work seems to be increasing again after having stabilised since 1997, but this change in trend is very recent and needs to be confirmed in the coming years. There is also a trend towards more working in excess of the contractual hours.

Moreover, the health of the Dutch workforce appears to be stable. Several legislative changes have been made with the aim of reducing the number of workers who enter the disability benefit system. This legislation has succeeded in doing that, although a slight increase has been found in work-related mental health complaints and RSI (Houtman, Smulders and van den Bossche, 2006); however, no increase in this regard is apparent from 2005 to 2006. Although the new legislation should have reduced the proportion of those leaving the workforce due to psychological disorders and entering the disability system, this was not the case.

Wendela Hooftman and Irene Houtman, TNO Work and Employment

Annex: Statistical sources

Netherlands Working Conditions Survey (NEA)

In 2003, the Netherlands Working Conditions Survey (*Nationale Enquête Arbeidsomstandigheden*, [NEA](#)) was started. At present, this survey is designed to replace the modules on working conditions and work-related health in the Permanent Quality of Life Survey (*Permanent Onderzoek Leefsituatie*, POLS) – about 25 items are directly derived from the former survey – and the NEA measures most concepts using scales, preferably validated scales. Validated scales are scales that have proven to be valid for the concept measured in previous research published on this topic.

Commissioned by the Ministry of Social Affairs and Employment ([Ministerie van Sociale Zaken en Werkgelegenheid](#), [SZW](#)), the NEA is carried out by [TNO Work and Employment](#), part of the Netherlands Organisation for Applied Scientific Research ([Nederlandse Organisatie voor toegepast-natuurwetenschappelijk onderzoek](#), [TNO](#)). Apart from the first wave in 2003, the survey has been conducted in cooperation with Statistics Netherlands ([Centraal Bureau voor de Statistiek](#), [CBS](#)). It is a postal or web survey and had a net response of approximately 10,000 employees in 2003. In 2005, the target net sample was 25,000 employees.

The survey was originally scheduled for every second year, but has become an annual survey since 2006. The NEA constitutes a representative sample of the Dutch workforce in the 15–64 year age group but excludes self-employed people. It is currently the largest survey on working conditions available in the Netherlands and serves as a national benchmark for sector-level monitoring studies on working conditions.

Permanent Quality of Life Survey (POLS)

From 1997 to 2004, the POLS was carried out each year by Statistics Netherlands. Since 1997, this survey is an ‘Integrated System of Surveys on Living Conditions’. It consists of a core interview that is administered to – depending on the year – between 40,000 and 90,000 people who have a registered address in the Netherlands. Some of these people also receive work and health questions, submitted to approximately 18,500 workers with a response of approximately 10,000 people each year – amounting to a response rate of 60% on average. Workers surveyed in the 18–64 year age group number about 4,500 persons; the sample is representative for the Dutch workforce. The POLS is a face-to-face interview. However, the questions on health are presented on paper, and the interviewees are asked to take this written questionnaire with them and send it back after completion. This may give an additional non-response rate on these questions.

Disability register

Another source of information on long-term absence from work is the Netherlands disability register, containing information on disability inflow, outflow and volume by diagnostic category. The Social Security Administration (*Uitvoeringsinstituut Werknemers Verzekering*, [UWV](#)) maintains the register. This source is an important monitoring system to keep track of the type of health problems related to long-term absence and the cost to society of people leaving the workforce.

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