REPORT

for the period from 1 July 2005 to 1 July 2011, made by the Government of the Netherlands, in accordance with article 22 of the Constitution of the International Labour Organisation, on the measures taken to give effect to the provisions of the

EMPLOYMENT INJURY BENEFITS CONVENTION, 1964 (NO.121)

Ratification of this Convention was registered on 2 August 1966.

I
Changes in legislation and administrative regulations etc. which apply to the provisions of the Convention.

Law of 16 November 2001, (Bulletin of new Laws 2001, 567) instituting several legal forms of leave such as maternity leave; adoption leave; foster leave; parental leave etc, as amended on 22 December 2005 (Bulletin of new Laws 2005, 708).

Law of 20 July 2004 (Bulletin of new Laws 2004, 357) instituting the abolition of the Self-Employed Persons Disablement Benefits Act (WAZ).[1]

Law of 10th November 2005 (Bulletin of new Laws 2005, 572) concerning the Work and Income according to Labour Capacity Act, as amended on 22 December 2005 (Bulletin of new Laws 2005, 710)

Law of 16 June 2005 (Health Insurance Act [Zorgverzekeringswet]) (Bulletin of Acts, Orders and Degrees 2006, 79), last amended by the Act of 26 February 2011 (Bulletin of Acts, Orders and Degrees 2011, 111)

Royal Decree of 28 June 2005 (Besluit Zorgverzekering) (Royal Decree on health insurance) (Bulletin of Acts, Orders and Degrees 2005, 389), last amended by Royal Decree of 23 December 2010 (Bulletin of Acts, Orders and Degrees 2010, 875)

Law of 16 June 2005 (Health care allowance act [Wet op de zorgtoeslag]) (Bulletin of Acts, Orders and Degrees 2005, 369), last amended by the Act of 26 February 2011 (Bulletin of Acts, Orders and Degrees 2011, 111)

Law of 14 December 1967 (Exceptional medical expenses act [Algemene Wet Bijzondere Ziektekosten]) (Bulletin of Acts, Orders and Degrees 1992, 392), last amended by the Act of 26 February 2011 (Bulletin of Acts, Orders and Degrees 2011, 111)

[1] From this date self employed persons have the possibility to take out private insurances. However, self – employed persons who did already receive a disability pension under the WAZ at the time of abolishment, continue to do so.

II

Article 2

No recourse is had to any temporary exceptions as mentioned in this Article.

Article 3

No such declaration has been made.

Article 4

As from 1998 the special social security system for civil servants ceased to exist, and as a result of this civil servants are also fully insured under the legislation covering sickness and disability.

A. No recourse is had to any clause of paragraph 2 of this Article.

B. No recourse is had to Article 4 (2) (d)

Article 5

Not applicable

Article 6

All employees who are disabled for a period of at least 104 weeks who are after that period for at least 35% occupational disabled are entitled to a benefit under the Work and Income according to Labour Capacity Act (WIA).
For in depth information concerning the WIA please see hereunder, under Article 13 and further the Direct Request, explaining in dept the provisions of the WIA.

Article 7

See Article 6.
There is no special Scheme concerning “industrial Accidents” as all employees are covered against long term disability under the WIA.
A person who is fully and permanently occupationally disabled, will receive disability benefit, regardless the course of the disability. In case one is fully and permanently for 80% occupational disabled to become eligible for benefit on the basis of the Income Provisions Scheme for People Fully Occupational Disabled (IVA).
In the case one is at least 35% occupational disabled, you will be entitled to benefit on the basis of the Return to Work Scheme for the Partially Disabled (WGA)For further information please see the explanation under Article 13.

Article 8

See Article 7

Article 9

A Yes, the benefits concerned are fully in accordance with this Article and are subject to such exceptions as are indicated in respect of Article 22 of the Convention.

B. No conditions with regard to the duration of the employment history or the duration of the insurance are imposed on the existence of the entitlement to a WGA benefit. So the insured person who becomes ill on his first working day is entitled to a WGA benefit, as long as the conditions for this are met. These conditions are:

- The insured person must be ill for 104 weeks. During this period he is entitled to continued payment of wages pursuant to the Sickness Benefits Act.
- After these 104 weeks he must be partially disabled, that is to say he must have a loss in earning capacity of at least 35%.
- No exclusion grounds apply after these 104 weeks, except in case of detention and residence outside the Netherlands.

The duration of the employment history or the duration of the insurance is therefore not a condition that determines whether one is entitled to a WGA benefit. The WGA benefit satisfies all the standards of Convention no. 121, both with regard to the granting conditions and the amount of the benefit.

C No such declaration has been made.

D. No recourse is had to this Paragraph.

Article 10

All persons legally residing in the Netherlands or non-residents who work and pay income tax in the Netherlands are insured for the Exceptional medical expenses act (Emea). As from January 1st 2006 everybody who is insured under the Emea is obliged to take out health care insurance under the Health Insurance Act. Everybody insured under Dutch social health insurance legislation is entitled to benefits in kind or to reimbursement of the costs of the medical care they received, referred to in Article 10, and this irrespective of the cause for the need of medical care.

Failure to fulfil the obligation to take out health care insurance under the Health Insurance Act gives rise to an undesirable situation –primarily for the uninsured persons themselves. Those who feel they do not need insurance may end up facing a serious illness or accident and are usually unable to pay the costs of the required care themselves. Second, this situation is not in the interest of the social insurance system. From the perspective of the insurance system, any violation of the principle of solidarity on which the system is based is undesirable.

Therefore a new law has been designed to ensure that uninsured persons are identified by means of database comparisons. This law is adopted and took effect on 15 March 2011. Uninsured persons will receive a reminder letter pointing out their obligation to take out health care insurance and summoning them to comply. If they refuse to comply, they will have to pay a penalty equal to three times the standard premium. A second penalty will be imposed if a new database comparison shows that the party in question is still not insured three months after the first penalty was imposed. The Health Insurance Board will take out insurance on behalf of anyone who is still uninsured after two penalties have been imposed. The person in question will then pay an administrative premium for 12 months equal to 100%, which amount, where possible, will be withheld at source. Before the law went into effect, extensive public awareness activities aimed at specific target groups were implemented in order to reduce the number of uninsured persons even further.

A. Benefits under the Health Insurance Act

• Medical care

Medical care consists of care provided by GPs, medical specialists, clinical psychologists and midwives. This does not necessarily mean that the care has to be provided by these people. Others may provide types of care that are not reserved treatments subject to registration and

title protection under the Individual Health Care Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*).
This care includes the associated laboratory tests and nursing.
It further includes advice on hereditary diseases, non clinical haemodialysis, chronically intermittent respiratory treatment and assistance rendered by a thrombosis prevention unit.
Until 2007, mental health care was covered under the Exceptional medical expenses act. Since 1 January 2008, mental health care (including primary psychological care) has been financed under the Health Insurance Act.

• Dyslexia care
This form of care is related to serious dyslexia suffered by primary school children. Dyslexia causes problems with reading and spelling and becomes apparent at school. The Health Insurance Act only reimburses the treatment of serious cases of dyslexia in primary school children.

• Paramedical care
Paramedical care includes physiotherapy, remedial therapy, speech therapy, occupational therapy and dietary advice. The entitlement of insured persons aged 18 and older to physiotherapy and remedial therapy is limited to the treatment of certain chronic disorders, excluding the first twelve treatments for such a disorder. Insured persons younger than 18 are entitled to nine treatment sessions per year for each disorder, which entitlement may be extended by another nine treatments.
Speech therapy must be provided for a medical purpose with the likelihood of recovery or improvement of speech function/capability.
Occupational therapy must be provided with a view to promoting and restoring the self-care and self-reliance of the insured person up to a maximum of ten treatment hours per year.
For dietary advice, there is an entitlement to reimbursement of up to four hours of treatment per year. The advice must be provided by dieticians and be for medical purposes concerning nutrition and eating habits.

• Oral care
In addition to regular check-ups and preventive maintenance work, young people under 18 are entitled to fluoride treatment no more than twice annually starting at the age of six and to sealing/periodontal care. Oral care for insured persons aged 18 and over is limited to specialized surgical dentistry (oral surgery), the associated X-rays and dentures. People with an exceptional dental disorder, physical/mental disability or special dental problems resulting from medical treatment are entitled to complete dental care (subject to special conditions).

• Pharmaceutical care
Pharmaceutical care consists of medicines and foods provided for medical purposes. In principle, the medicines are divided into groups of medicines that are therapeutically interchangeable. The maximum reimbursement for such a group is set according to the average price of the medicines in the group. An insured person who chooses a more expensive medicine must pay the difference. There is no reimbursement limit for a medicine included in the cover, which cannot be substituted by other medicines. This system is referred to as the ‘medicines reimbursement system’.
Taking into account the orchestrating role that care insurers play, they are permitted to limit the reimbursable medicines to those they designate in each group.

• Medical devices
The medical devices covered by the insurance are mainly those that people use at home. The content of the cover varies from personal care items (e.g. incontinence materials and diabetes test strips) to equipment (e.g. hearing aids and orthopedic footwear). Insured persons need the care insurer's approval for the purchase of medical devices. Insured persons are entitled to efficiently working devices appropriate to their limitations.

• Accommodation
Accommodation related costs associated with stays in care institutions considered necessary for the provision of medical care are limited to an entitlement of 365 days. The costs incurred after 365 days are charged to the Exceptional medical expenses act. Accommodation under the Health Insurance Act includes entitlement to nursing and care, but this does not necessarily have to be provided in a health care institution.

• Maternity care
This concerns care for mother and baby for up to ten days after childbirth. There is no cost sharing for maternity care on medical indication.

• Transport of patients
This includes the transport of patients by ambulance, taxi or private car, provided this is medically indicated. The doctor treating the patient is required to issue a transport certificate. The entitlement further includes the costs of public transport in the lowest class to and from a health care institution. In certain cases, the care insurer may agree to special modes of transport like a helicopter.
The right to transport in a vehicle in which the patient is carried in the normal sitting position is confined to four situations (i.e. kidney dialysis, chemotherapy/radiotherapy, people with a visual impairment who are unable to travel unaccompanied, and wheelchair users). A maximum one-way journey of 200 kilometers applies. Travel over longer distances is permitted for patients who – with the care insurer's prior consent – receive insured treatment from a health care institution or care provider located farther away (in the Netherlands or abroad). The insurance includes a hardship clause under which insured persons who do not fall into any of the categories described above nevertheless receive reimbursement. This may be the case, for example, if an insured person requires transport for an extended period to receive treatment for a chronic illness or disorder.

Cost sharing under the Health Insurance Act 2011
Medical care: There is a compulsory deductible for insured persons aged 18 and older for certain health care under the Health Insurance Act with a maximum of € 170 per year for 2011. This obligatory personal excess does not apply to GP, maternity and obstetric care. Furthermore obligatory personal excess does not apply to dental care for insured persons under 18. However, it does apply to all other forms of care in the basic health insurance package. Those who incur structural care expenses over time, for example, due to chronic illness or disability receive financial compensation. As a result, they do not pay more in terms of obligatory personal excess than an average insured person who receives no compensation.
Psychological care: Insured persons pay a personal contribution for each session of primary psychological care of € 10 per session.
Paramedical care: The entitlement of insured persons aged 18 and older to physiotherapy and remedial therapy is limited to the treatment of certain chronic disorders, excluding the first twelve treatments for such a disorder.

Oral care: Oral care for insured persons aged 18 and over is limited to specialized surgical dentistry (oral surgery) the associated X-rays, dentures. Personal contribution to dentures is 25% of the cost. For a dental prosthesis to be placed upon a dental implant an amount of maximum € 125 is to be contributed.
Medical devices: For orthopedic shoes the personal excess for persons younger than 16 is € 68,50 per pair, for persons aged 16 and over € 136,50. Hearing appliances: payment by insured person of age 16 and over: the difference between the purchasing costs and the costs higher than € 501,50/€ 683 depending on age and price of the appliance.
Maternity care: In case of not-medically-necessary hospitalization because of confinement, the mother as well as the child has to pay an excess of € 15,50 per day plus the amount of the tariff of the institution exceeding € 110,50 per day. Maternity care (without medical indication) at home an amount of € 3,90 per hour has to be paid.
Transport: An insured person is required to pay an amount of € 91 per 12 months for travel by public transport, taxi or private car. The costs of travel by private care are reimbursed through payment of the costs exceeding € 0,25 per kilometer up to 200 kilometer and all costs of travel exceeding 200 kilometer.

B. Benefits under the Exceptional medical expenses act
To be eligible for care under the Exceptional medical expenses act, insured persons have to have a certain disorder, limitation or disability, meeting what is referred to as an indication principle. Outlined in the Exceptional medical expenses act, these six indication principles are:
• Somatic (physical) illness, disorder or disability.
• Psycho-geriatric disorder or disability.
• Psychiatric disorder or disability.
• Mental disability.
• Physical disability.
• Sensory disability.
The Exceptional medical expenses act and subsequent regulations determine the entitlements to care under the Exceptional medical expenses act. Procedural rules have been laid down for such matters as invoking certain entitlements to care or obtaining the prior consent of the implementing body. Insured persons can obtain care under the Exceptional medical expenses act after the Care Indication Determination Centre has determined that the care is indicated.

Function-based entitlements
Entitlements under the Exceptional medical expenses act are defined in terms of functions. The focus is no longer on the available supply of care offered, but on the needs of the insured persons. This leads the way to the provision of customized care. The need to shift away from a supply side to a demand side approach can be attributed to a changing society in which people increasingly voice their preferences and requirements and want to organize their lives in the manner they see fit. The guiding principle of the Exceptional medical expenses act is also to ensure that people live at home for as long as possible, enabling them to receive care both at home and in an institution.

Functions
The broad definitions of the five functions offers considerable freedom in arranging the indicated care in consultation with a care provider. The functions are:
• Personal care (e.g. providing assistance with showering, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking).

• Nursing (e.g. dressing wounds, administering medication and injections, showing patients how to administer injections).
• Supportive guidance (e.g. helping others to organize the day and manage one's life better or learn look after one's household, both individually and as part of daytime activities).
• Treatment (e.g. specific treatment by a geriatric specialist, a doctor for the developmentally disabled or a behavioral scientist).
• Accommodation: Some are unable to continue living independently (e.g. when they require sheltered housing or continual supervision in connection with serious absent-mindedness). Inpatient care may also be necessary when the care needs are too great to address in the home environment.

Care is provided in the form of 'products'. For example home care, admission to a care home, nursing home, institution for the developmentally or physically disabled are all products offered under the Exceptional medical expenses act. A product consists of a single function or a combination of functions.
In addition to care functions, there is also an entitlement to, for example, patient transport, nursing supplies, care and support related to sign language, hospital care after one year, rehabilitation care, prenatal care, research into certain congenital metabolic disorders, and vaccinations included as part of a vaccination programme.

Personal contribution under the Emea
For most types of care under the Exceptional medical expenses act, those aged over 18 have to make a personal contribution, the amount of which depends on such aspects as taxable income and living situation (i.e. living at home or in an institution). Other relevant factors are whether insured persons are younger or older than 65 and whether they are married or cohabit. The personal contribution is deducted directly from the personal care budget (if applicable). Insured persons who pay a personal contribution towards care in-kind will either receive a bill or the amount of the contribution is set off against any state government support. In 2011 cost sharing in case of residential care in an institution from the age of 18 amounts to the so called low contribution (during the first six months of stay with a maximum of € 764.40 a month) and a so called high, income related contribution after six months of stay (with a maximum of € 2,097.40 a month).

Article 11
Recourse is made to article 11.

A. Under Dutch health insurance legislation, each person who is in need of medical care is entitled to the benefits in kind or reimbursement of the cost of such care referred to in the Health Insurance Act and the Exceptional medical expenses act, irrespective of the cause for the need to medical care.
B. For an overview of limitation in duration, number of treatments or costs in Dutch health insurance legislation, reference is made to the report on article 10.

Article 12
Not applicable

Article 13

A. Recourse is had to the provisions of Article 19
B. (i) Article 19

Title I of Article 19

A. Rules for the calculation of the benefit.
Recourse is had to the provisions of paragraph 3 of Article 19
The maximum daily pay taken into account by calculating the benefit is € 188.88 at 30th June 2011

B Recourse is had to clause (b) of paragraph 6.

1. (a)(i)

Reference is made to Annex I, Major Division.

(ii) The wage of the skilled male manual employee is provided by the Central Bureau of Statistics (CBS).

2. The salary, pension and child benefit are calculated at the same time base, i.e. 30 June 2011.

A. The wage of the skilled male manual employee is determined at € 2.708,33 gross per month.
1. Benefits do not vary per region.
2. Not applicable.

Title II of Article 19

D. Amount of benefit during the time base:
70% of 2.708,33 = 1.895,83 euros gross per month.

E. Amount of family allowances during employment: € 204.99 per month[2]

F. Amount of family allowances allocated while receiving benefits: € 204.99 Per month

G. (D+F)(C+E) = 75 %

Title IV of Article 19

D. Amount of benefit during the time base:
70% x € 2.708,33.00 =€ 1.895,83 euros gross per month

G. D/C = 75%

Title V of Article 19

No minimum amount has been prescribed.

Article 14

[2] Family with two children between the age of 0-6 years, born after 31 December 2004 plus 75 Euro supplement

A. See under Article 13

B. Recourse is had to Article 19

C (i)

Title I of Article 19

B. Recourse is had to the provisions of Article 19

C. 1.

(i) Article 19
Title 1

A. Rules for the calculation of the benefit.
Recourse is had to the provisions of paragraph 3 of Article 19
The maximum daily pay taken into account by calculating the benefit is € 188.88 at 30th June 2011

B Recourse is had to clause (b) of paragraph 6.

1.
(a)(i)
Reference is made to Annex I, Major Division.

(ii)

2. The salary, pension and child benefit are calculated at the same time base, i.e. 30 June 2011.

C The wage of the skilled male manual employee is determined at € 2.708,33 gross per month.
1. Benefits do not vary per region.
2. Not applicable.

Title II of Article 19

D. Amount of benefit during the time base:
70% of € 2708,33 = € 1.895,81 gross per month.

E. Amount of family allowances during employment: € 204.99 per month[3]

F. Amount of family allowances allocated while receiving benefits: € 204.99 per month.

G. D+F/C+E = 75 %

[3] Family with two children between the age of 0-6 years, born after 31 December 2004 plus 75 Euro supplement.

Title IV of Article 19

D. Amount of benefit during the time base:
70% x 2.708,33 =€ 1.895,81 euros gross per month

G. D/C = 70%

Title V of Article 19

No minimum amount has been prescribed.

Article 15
Not applicable

Article 16
Not applicable

Article 17
See previous Reports.

Article 18
A. (i) and (ii) and (iii)

B. Recourse is had to the provisions of Article 19

C. (i)

Title I of Article19

A. Rules for the calculation of the benefit.
Recourse is had to the provisions of paragraph 3 of Article 19.
The maximum daily pay taken into account by calculating the benefit is 188.88 Euros at 30th June 2011

B. Recourse is had to clause (b) of paragraph 6

1. (a)(i)
Reference is made to Annex I, Major Division.

(ii)

2. The salary, pension and child benefit are calculated at the same time base, i.e. 30 June 2011.

C. The wage of the skilled male employee is determined at € 2.708,33 gross per month.

1. Benefits do not vary per region.

2. Not applicable.

Title III of Article 19

D.	Amount of benefit during the time base:	€ 1.034,38 per month
E.	Amount of family allowances during employment	€ 204,99 per month
F.	Amount of family allowances during contingency	€ 204,99 per month

G, C + E / D +F x 100% = 51%.

Title IV of Article 19

D. Amount of benefit granted during the time base:
70% of € 2.708,99 = .€ 1.895,83 gross per month.

G. D/C = 75%

Title V of Article 19

No minimum amount has been prescribed.

Article 21

2.	Period under review	Cost of living index	Index of earnings
A.	Begin of period (1 July 2005)	98.52	112.4
B.	End of period (March 2011)	109.02	125.3
C.	Percentage $\frac{A}{B}$	90.36	89.70

(2006=100).

Hereunder are compared the maximum daily pay taken into account when calculating disability allowances.

Period under review	Maximum daily pay
A. 1 July 2005	165.00
B 30 June 2011	188.88

C.percentage $\frac{A}{B}$ = 87.85

Article 23
No changes, see previous reports

Article 24
No changes, see previous reports

Article 25
No changes, see previous reports

Article 26
Concerning rehabilitation services the Government refers to its report under ILO Convention 159, "Vocational Rehabilitation and Employment" (disabled persons) Convention, Chapter "Developments within the Netherlands concerning reintegration".

Article 27
No distinction is made between national and non-nationals concerning the entitlement to benefits

Observation
With a view to the report on the application of the Convention 121 sent by the Dutch Government to the ILO on 8 October 2009 the Committee requested to give particular attention in the forthcoming detailed report to examining the extent to which the Dutch legislation, especially following the privatization of the health-care branch continues to ensure protection against contingencies (a), (b) and (d)[4] *on conditions and at the level required by the Convention. In view of the fact that, as indicated in the report, victims of employment injuries are required to share costs for certain types of medical care, and are subject to limitations in duration and number of treatments, the Committee asks the Government to examine whether victims of employment injuries in need of prolonged care or particularly expensive treatment find themselves in a situation of hardship*.

Answer of the Government
As the Committee states the Dutch health care insurance is organized under private law. However, the Dutch government has chosen to incorporate statutory safeguards in the Health Insurance Act to protect the social nature of health insurance. Persons under the obligation to take out health insurance who apply for insurance, have to be accepted. Furthermore the insurance cover and the associated terms and conditions have to be the same for everyone.

Concerning the direct request of the Committee the government informs the Committee as follows:

Compulsory deductible
There is a compulsory deductible for insured persons aged 18 and older for certain health care under the Health Insurance Act with a maximum of € 170 per year for 2011. This obligatory personal excess does not apply to GP, maternity and obstetric care. Furthermore obligatory personal excess does not apply to dental care for insured persons under 18. However, it does apply to all other forms of care in the basic health insurance package.

[4] (a): general practitioner and specialist in-patient and out-patient care, including domiciliary visiting;
(b) dental care;
(c) maintenance in hospitals, convalescent homes, sanatoria or other medical institutions.

Those who incur structural care expenses over time, for example, due to chronic illness or disability receive financial compensation. As a result, they do not pay more in terms of obligatory personal excess than an average insured person who receives no compensation.

The compulsory deductible mentioned above came into force on 1 January 2008. Until then a no-claim refund scheme for insured persons aged 18 and older had been into force. Insured persons who used little or any health care under the Health Insurance Act got back part of the contribution they had paid. As under the current scheme the no-claim scheme excluded the costs of care such as provided by general practitioners and the costs of midwives and maternity care.

Allowances for chronically ill and disabled persons
Chronically ill and disabled persons often incur extra care expenses. Up to 1 January 2009 cost of medical care were deductable from the taxable income insofar as no reimbursement under the social health insurances had been provided. This scheme made it possible to deduct medical expenses from the taxable income, as a result of which people paid less tax or even received a refund. As of 1 January 2009 this possibility was replaced by the Chronically Ill and Disabled Persons (Allowances) Act (Wet tegemoetkoming chronisch zieken en gehandicapten [Wtcg]). The Wtcg consists of a number of measures to compensate for the abolition of the extraordinary expenditure scheme.

1. General allowance.
   Every year, the chronically ill and disabled automatically receive a general allowance if they fulfill one or more of certain conditions (such as: at least 26 weeks of care under the Emea in a care institution, received rehabilitation care in or by a certified rehabilitation centre, received physiotherapy or remedial therapy due to a chronic disorder, received hospital care or use of certain types of medicines due to a chronic illness). Whether a person is eligible for a general allowance and, if so, the amount involved depend on the age and the use of care.
2. Discount on the Emea personal contribution for residential care or home care.
   The discount for people aged 65 or older is 8%, while those under the age of 65 receive a 16% discount.
3. New fiscal scheme for specific care expenses.
   Certain care expenses are tax deductable insofar as no reimbursement or allowance has been provided. Tax deductible are prescribed medicines and medical assistance, additional family help, additional clothing and bedclothes, diet prescribed by a doctor, medical devices, patients visits and transport.
4. Compensation for the elderly.
   Since 1 January 2009 people aged 65 or over receive a higher allowance on the payment under the General Old Age Pensions Act. The elderly person's tax credit and the income limit have been raised for this compensation. As a result more people aged 65 or over are eligible for the elderly person's tax credit.
5. Allowance for those unfit for work.
   People insured under the Emea who are unfit for work (rating of 35% unfit or over) and who receive invalidity benefit from the Institute for Employee Benefits Scheme[5] get a net annual allowance of € 336.

[5] It makes no difference whether the benefit is made possible under the terms of the Invalidity Insurance Act (*Wet op de arbeidsongeschiktheidsverzekering*), Work and Income (Capacity for Work) Act (*Wet werk en inkomen naar arbeidsvermogen*), Return to Work (Partially Disabled Persons) Scheme (*Regeling Werkhervatting Gedeeltelijk Arbeidsgeschikten*), Fully Disabled Persons Income Scheme (*Regeling Inkomensvoorziening*

The compensation measures mentioned above (the compulsory deductible and the allowances for chronically ill and disabled persons) are taken to ensure that cost-sharing does not involve hardship for the persons insured under the Health Insurance Act and the Emea.

Cost sharing
Cost sharing under the Health Insurance Act and the Exceptional medical expenses act together amount to approximately € 3,2 billion. The expenditure under the acts mentioned amount to approximately € 61,7 billion (National budget 2011). The part of the cost sharing amounts to about 5% of the cost of health insurance. In comparing the cost sharing in the Netherlands with surrounding countries it can be stated that the extent of cost sharing in the Netherlands is limited. In the European Code a percentage of 25% is mentioned as the maximum average amount of cost sharing by the insured of the total cost of health care under the Health Insurance Act, the Exceptional medical expenses act and the Social Support Act (Wet maatschappelijke ondersteuning).

There has been no considerable change in cost sharing, limitations in duration and number of treatments under the Health Insurance Act that came into force on 1 January 2006 in comparison with the Social Health Care Insurance Act that has been repealed as of 1 January 2006. Neither has there been a considerable change in cost sharing under the Exceptional medical expenses act before or after the date mentioned.

As known to the Committee the Netherlands has denounced Part VI of the European Code of Social Security and has ratified the revised European Code on Social Security.
The decision of the Netherlands to denunciate Part VI of the European Code resulted from the fact that the Central Appeals Tribunal in Utrecht, the highest judicial authority in the area of social security, had ruled that cost sharing by persons in need of long-term intramural care as a consequence of occupational illness or industrial accidents, contravened with Part VI of the Code. The decision in this case resulted from the fact that the Netherlands' legislation on social security does not make any distinction between the 'risque social' and the 'risque professionnel'. The revised European Code on Social Security lacks the prohibition of cost sharing for care as a consequence of occupational illness or industrial accidents.
Until now (May 2011) the Netherlands is the only country that has ratified the revised European Code on Social Security. Not until at least one more country does ratify the revised Code the European Code will remain in force. Until the coming into force of the revised European Code the Netherlands has to report on the European Code and remain unable to comply with the conditions and the level required by the Convention of the European Code concerning cost sharing with a view to Part VI of the Code. The Netherlands government asks the Committee to be lenient in its appreciation on this matter.

Observations WIA

- *Prescribed degree of the loss of earning capacity*

The Committee regrets the Government's position, and notes that the Government, while recognizing non fulfilment of its international obligation under the directly applicable provision of the Convention, has not yet brought national law and practice into compliance

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volledig arbeidsongeschikten), Invalidity Insurance (Young Disabled Persons) Act (*Wet arbeidsongeschiktheidsvoorziening jonggehandicapten*) or the Invalidity Insurance (Self-Employed Persons) Act (*Wet arbeidsongeschiktheidsverzekering zelfstandigen*).

with the Convention on this point and leaves victims of employment injuries with incapacity up to 35 per cent without any form of compensatory benefit.

- *The Income Provision Scheme for Fully Occupationally Disabled Persons (IVA)*

The Committee observes that the IVA scheme could be made fully consistent with the Convention by deleting section 6.2.2 of the WIA. It would therefore invite the Government to consider this option with a view to enhance the social protection and well-being of fully disabled persons in line with the Convention, taking into account the likely minimal financial impact of this measure on the insurance scheme.

- *The Return to Work Scheme for the Partially Disabled (WGA)*

The Government states that no conditions with regard to the duration of the employment history are imposed on the entitlement to a WGA benefit, which satisfies all the standards of the Convention. While noting this statement, the Committee requests the Government to explain in further detail to what benefits the abovementioned sections 7.1.1 and 7.1.5 of the WIA refer and how one should understand their provisions.

Taking into account that the Convention does not permit subjecting the entitlement to the benefit to an obligation to make use of the remaining earning capacity, the Committee would ask the Government to consider bringing the regime of legal obligations and sanctions imposed by the WIA on the recipients of the follow-up WGA benefit into line with Article 22 of the Convention.

- *The level of benefits*

The Committee invites the Government to explain its position, including the provision of additional information with respect to this level of benefit situation.

Answer of the Government

Recently, the Committee of Experts (hereinafter referred to as "the Committee") explained its point of view on the question as to whether the Work and Income (Capacity for Work) Act (WIA Act) is in accordance with the standards laid down in Convention no. 121. Below follows a response to this point of view and the questions asked by the Committee. Before dealing with the specific points from the point of view of the Committee, the drafting and effects of the WIA Act will be dealt with in a general sense.

1. The WIA Act was drafted with due care

The WIA Act was introduced on 29 December 2005. The drafting of the WIA Act was preceded by an elaborate discussion. In 2001, an independent committee of experts gave its advice about the future policy concerning incapacity for work in the Netherlands. Subsequently, the Social and Economic Council (SER), on which employers' organisations, employees' organisations and Crown-appointed members have a seat, gave two recommendations on the policy concerning incapacity for work.

Moreover, two social agreements (2003 autumn agreement and 2004 autumn agreement) between employers’ and workers’ organisations and the government contained agreements about the design of the WIA Act.
The 2003 autumn agreement contained specific agreements about the level of the subsequent benefit under the Return to Work (Partially Disabled) Regulations. The methodology set out in the 2003 autumn agreement with regard to the level of the subsequent benefit - which amounts to 70% of the statutory minimum wage multiplied by the degree of incapacity for work - was included in the WIA Act. Moreover, it was agreed upon in the 2003 autumn agreement that it will not be checked whether the partner of the person concerned has income.

Additional agreements about the design of the WIA Act were included in the 2004 autumn agreement of 5 November 2004. Furthermore, the employers' and workers' organisations noted down in the autumn agreement that they *are of the opinion* that the government proposal sufficiently took over the outlines of the SER recommendations on reviewing the WAO.
Furthermore, this autumn agreement explicitly states that the group of employees who are partially unfit for work (35% or less) requires customised solutions at the level of the labour organisation.

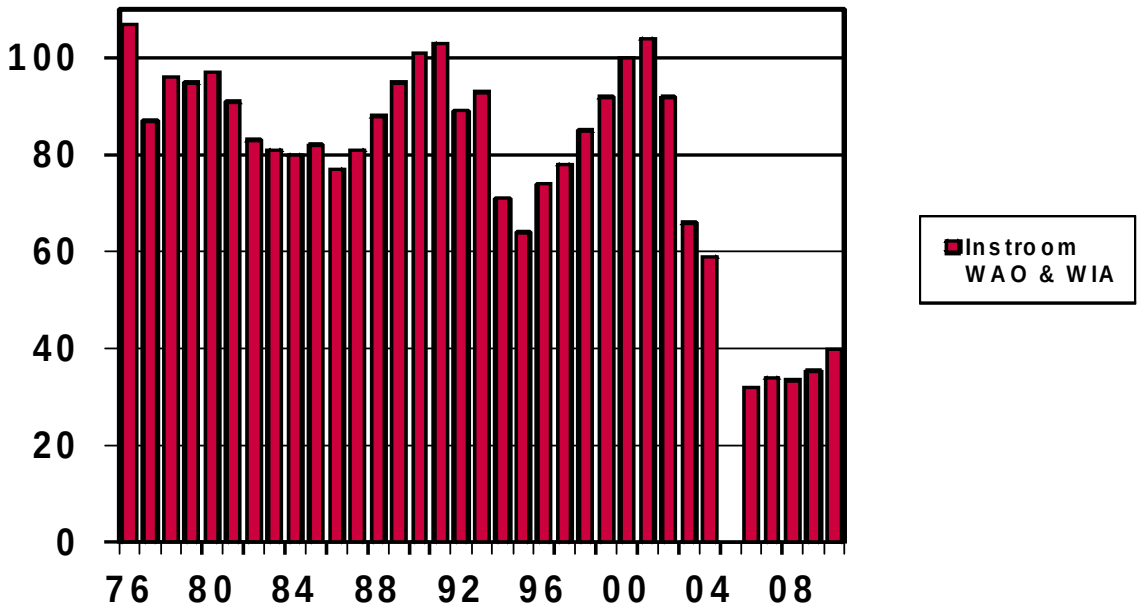
The above shows that the WIA Act was drafted with due care and with the agreement of the employers' and workers' organisations.

2. The effects of the policy concerning incapacity for work in the Netherlands

The WIA Act is the final stage of a series of measures taken as from the mid 1990s in order to reduce the long-term sickness absence and the appeal to invalidity benefit schemes. These measures have turned a passive benefit system into an active system which focuses on a person's abilities despite any incapacity for work. For this purpose, employers and employees are stimulated now more than ever to continue to use the remaining possibilities of performing work. Until the end of the 1990s, the Netherlands had the highest number of people claiming invalidity benefit in the world. The series of measures taken included the introduction of differentiation in contributions in invalidity insurance (the Invalidity Insurance (Differentiation in Contributions and Market Forces) Act) in 1998, the introduction of the Eligibility for Permanent Incapacity Benefit (Restrictions) Act (2002), the extension of the period of continued payment of wages to two years (2004) and the introduction of the WIA Act (2006).

An analysis of the effect of various measures on the chance that people start to claim invalidity/WIA benefit shows that this number of people has decreased by 71% between 1999 and 2009. About half of this decrease is related to two acts, namely the Invalidity Insurance (Differentiation in Contributions and Market Forces) Act from 1998 and the Eligibility for Permanent Incapacity Benefit (Restrictions) Act from 2002.
The other half of the decrease results from the three measures that are related to the introduction of the WIA Act: the tightening of the Assessment Decree from 2004, the extension of the period of continued payment of wages during sickness from 2004 and the introduction of the WIA Act itself in 2006.

Table 1 is a diagram of the trends in the number of people starting to claim a benefit under the invalidity scheme in the long term.



Instroom WAO& WIA: Number of people starting to claim WAO and WIA benefit.

The decrease in the number of people starting to claim WAO and WIA since the beginning of this century has not been accompanied by an increase in the numbers claiming unemployment benefit or social assistance. If this policy had not been followed, in the long term, the number of those unfit for work would have risen to 1.2 million people. In the long term, we now expect the figure to rise to less than 500,000 people who are unfit for work. The policy has effectively meant that a greater number of people are still on the labour market, and has thus contributed to the realisation of a more inclusive job market. This is important from various points of view.

- It is firstly in the interest of individual employers and employees. Employers directly benefit from the fact that employees can be employed in their companies. For employees, work is important in the sense that it contributes towards their social development and offers a stable source of income;
- It is secondly of importance for the sustainability of the occupational disability system. Researchers recently calculated that if it had not been for the policy, in 2010, occupational disability costs would have been € 4 billion greater than was actually the case.
- There is thirdly an economic interest. The decrease in long-term absence due to illness and occupational disability has led to a larger number of employees available for employment on the job market. This is important, especially with a view to the anticipated decrease in the workforce.

The decrease in the number of people staring to claim these benefits also allows benefits to be kept up to standard. The fully disabled maintain their entitlement to a benefit of 70% or 75% of the daily wage (in the event of sustainability) until they reach the pensionable age. This is a considerable improvement compared to the WAO.

- Internationally too there is a great deal of interest in the WIA system. Among others, the OECD has spoken favourably of the policy measures taken in the Netherlands. In a comparative country survey, the OECD stated the following. “When it comes to sickness and disability, no other OECD country has such an interesting story to tell as the Netherlands. First, sickness absence fell from 10% in the late 1980s to only 4% today. More recently, the inflow into disability benefit also dropped remarkably, from almost 12 per 1000 in 2001 (and in fact during most of the two decades prior to the turn of the century) to around four per 1000 in 2007. Eventually, from 2005 onwards, the total number of people on disability benefit also started to fall. This success is a consequence of a series of very comprehensive reforms, characterised by a shift of responsibilities to employers and employees, a tightening in benefit eligibility and generosity, and a (partial) privatisation of hitherto public schemes.” (OECD, Sickness, disability and work: breaking the barriers, vol. 3 Denmark, Finland, Ireland and The Netherlands).

3. Position of employees who are less than 35% unfit for work

The introduction of the WIA Act meant an increase of the lower limit for the degree of occupational disability above which a person is eligible for invalidity benefit from 15% to 35%. This increase followed the advice of the Social and Economic Council (SER) with regard hereto and explicit agreements were made on it with employers’ and workers’ organisations in the 2004 autumn agreement. This social agreement states explicitly that for the group of employees with a light disability (35% or less unfit for work), customised solutions need to be realised at industrial organisation level. Employers’ and workers’ organisations have monitored the effects of the policy for this group themselves. These evaluations show that the percentage of people in employment who are less than 35% unfit for work and who fell ill while in permanent employment showed an increase. In 2009 64% of this group were employed. The group not (fully) working may be able to claim unemployment benefit (WW) or social assistance benefit. Trends in the group of employees less than 35% unfit for work who were not in permanent employment when they fell ill depict a much less favourable picture. Of this group, in 2009, approximately 35% were at work. The government is preparing measures to reduce long-term absence due to illness in this group, and to stimulate the speedy resumption of work.

Furthermore, with regard to the position of employees who are less than 35% unfit for work, it is of importance that although the lower limit has been increased from 15% to 35%, due to the considerable decrease in the number of people with a long-term illness, the absolute number of people whose application for invalidity benefit is turned down has fallen substantially. In illustration, in 2002, 71,000 applications for WAO were still turned down, while in 2009, the figure was only 17,000.

4. Point by point reaction to the points mentioned by the Committee of Experts

Below, the points brought forward by the Committee of Experts are examined point by point.

a. Prescribed degree of loss of earning capacity

In order to qualify for benefit on the grounds of the WIA Act, an employee must have a degree of occupational disability of 35% at the minimum. According to the Committee, this threshold is too low to comply with Convention no. 121. The Committee notes that Article 14, first paragraph of this convention allows a lower limit to be prescribed above which benefit

payments are provided. In the event of a degree of occupational disability under this limit (e.g. less than 10%), no benefit payment has to be paid. The Committee moreover notes that in some cases, it has accepted that a lower limit of less than 10% is compatible with the convention and that incapacity below 25% could be regarded as not substantial and compensated by lump-sum payments. In view of the fact that in the Netherlands, employees who are less than 35% unfit for work do not receive income protection in case of industrial accidents or occupational illness, according to the Committee, this lower limit is in breach of the convention. The Committee adds that the possibility for an employee to qualify for a benefit payment on the grounds of the Unemployment Act (WW) or the Work and Social Assistance Act (WWB) is not relevant within the legal framework of the convention. The Committee lastly remarks that it is regrettable that while the Dutch government acknowledges that it fails to comply with the international obligation laid down in the afore-mentioned provision of Convention no. 121, it does not wish to bring its national legislation and practice with regard to this point into line with the convention, as a result of which victims of industrial accidents or occupational illness who are less than 35% unfit for work fail to receive any form of income protection whatsoever.

In response hereto it is firstly noted that Article 14, first paragraph of Convention no. 121 determines that benefit should be granted if the degree of occupational disability exceeds a 'prescribed degree'. On the grounds of Article 1 of the convention, 'prescribed' is understood to mean 'determined by or on the strength of national legislation'. In other words, national legislation has a large degree of policy freedom in determining the afore-mentioned lower limit. The fifth paragraph of Article 14 limits this freedom in the sense that the lower limit must be set at a level that does not lead to those concerned finding themselves in financial 'hardship'. This last term is not further described in the convention.

In view of the large degree of policy freedom enjoyed by the national legislator has with regard to this point, the Dutch government is surprised that the Committee is so decided in its opinion that the lower limit of 35% in the WIA Act is too high. This opinion is not further explained by the Committee. The Committee has also failed to present arguments explaining why in its view, the possibility that an employee who is less than 35% unfit for work can claim a benefit payment on the grounds of the WW or the WWB is not relevant within the legal framework of Convention no. 121. It is therefore unclear to the Dutch government on the basis of which considerations the Committee has arrived at its opinion with regard to this point. These considerations are all the more important with a view to the fact that the convention allows the national legislator a great deal of space.

The Dutch government is of the opinion that the lower limit of 35% in the WIA Act is in line with Article 14 of Convention no. 121. This position is based on the following two considerations. This lower limit has firstly been carefully set, notably after consulting the employers' and workers' organisations. The Social-Economic Council (SER), in which the representative organisations of employers and employees area represented, suggested this lower limit in its advice of 2002 on the new occupational disability system. In response to the 2004 autumn agreement, the employers' and workers' organisations declared that the main points of the afore-mentioned advice and the subsequent advice of the SER in 2004 had been sufficiently complied with in the WIA Act. The 35% threshold in the WIA Act was therefore set on the advice of and with the agreement of the employers' and workers' organisations. Moreover, on the basis of the afore-mentioned autumn agreement, the employers' and workers' organisations declared themselves responsible for employees less than 35% unfit for work and in permanent employment. At the level of the industrial organization, customised

solutions need to be found for this group. Employers' and workers' organisations are increasingly successful in this regard. In 2009, 64% of this group were at work.

Secondly, the lower limit does not lead to 'hardship' for employees who are less than 35% occupationally disabled. They can, after all, claim entitlement to other national insurance schemes or social security benefits. An employee who is less than 35% occupationally disabled after two years, for example, is entitled to an unemployment benefit (WW), provided that s/he complies with the relevant conditions. If s/he is fully unemployed, the sum of this benefit in the first two months is 75% and subsequently 70% of his last-earned salary. The duration of this benefit will depend on his employment history. Thereinafter or if the employee fails to meet the conditions for entitlement to WW benefit, s/he can apply for social assistance (WWB benefit). Under the WWB, an employee can receive a benefit payment for the necessary costs of living. Employees who are less than 35% unfit for work do not therefore need to find themselves in reduced circumstances. In addition to these social security schemes, an employee who has become unfit for work as a result of an industrial accident or occupational illness can hold his employer liable for the damage and loss suffered as a result. This damage and loss includes loss of income as a result of occupational disability. Article 6:578 of the Dutch Civil Code even has a separate, favourable scheme for employees for this purpose, which due to developments in the legal system favours strict liability for employers. The Dutch government does not therefore agree with the Committee that victims of industrial accidents or employees with an occupational illness who are less than 35% unfit for work fail to receive any form of income protection in the Netherlands. Otherwise than argued by the Committee, the Dutch government does not agree that with regard to this point, the Netherlands fails to comply with its obligation on the grounds of Convention no. 121.

b. Income insurance for the fully and permanently occupationally disabled (IVA)
The amount of benefit on the grounds of IVA is 75% of the daily wage. If in spite of the fact that s/he is permanently fully occupationally disabled a benefit recipient nevertheless receives income from employment, 70% of that income is deducted from the IVA benefit. According to the Committee, the convention does not allow the benefit to be reduced if a fully occupationally disabled person receives income from employment.

In response hereto, it should be noted that Convention no. 121 does not contain a provision stipulating whether and if so the way in which any income from employment can or should be set off against a benefit payment. In substantiation of its position, the Committee also fails to refer to a specific convention provision. However, the absence of such a provision does not self-evidently lead to the conclusion that income from employment is not permitted to be set off against a benefit payment. The convention also has no provision prohibiting such setoff. In other words, the convention leaves this matter open.

The Dutch government is of the opinion that the system of income setoff opted for in the IVA is in line with the purport of Convention no. 121. On the grounds of Article 19, first paragraph and Article 20, first paragraph of this convention, in the event of full occupational disability, the benefit must amount to at least 60% of the last-earned wage and/or the statutory minimum wage. The IVA complies more than satisfactorily with those minimum norms, in view of the fact that in case of permanent full occupational disability, the benefit is 75% of the last-earned wage, provided that this is lower than the maximum daily wage. In other words, 75% of the wage loss (up to a certain maximum) is compensated by the IVA.

If someone receives income from employment, s/he is no longer actually fully occupationally disabled. In this case, the benefit he receives must be in reasonable proportion to the benefit s/he would receive in case of full occupational disability. (See Article 19, fifth paragraph and Article 20, third paragraph of Convention no. 121). The IVA also complies with this norm. As only 70% of the income from employment is deducted from the IVA benefit, even more than 75% of the actual loss of income, i.e. the daily wage minus income from employment, is compensated. This moreover means that the total income received by a person entitled to benefit always increases if s/he obtains income from employment. On the grounds of the foregoing, the Dutch government is of the opinion that the income setoff system in the IVA is consistent with Convention no. 121.

c. Wage-related benefit on the grounds of the Return to Work Scheme for the Partially Disabled (WGA)

An employee who after 104 weeks of illness is at least 35% unfit for work is entitled to benefit under the WIA Act. If s/he is permanently fully occupationally disabled, s/he will qualify for benefit on the grounds of the IVA. If not, s/he will be entitled to benefit on the grounds of the WGA. This last right is not subject to any conditions with regard to the duration of his/her employment history, the term of the relevant insurance scheme or the payment of contributions. Article 9, second paragraph of Convention no. 121 is therefore complied with.

Concerning the structure of the WGA, the Committee notes that on one hand, it ensures that the partially occupationally disabled receive automatic compensation for their loss of income as a result of unemployment, while on the other, they are immediately stimulated to resume work and to make use of the facilities to speed up the process of re-integration. Due to the latter, according to the Committee, as defined in ILO standards, the wage-related WGA benefit must be regarded as unemployment benefit. In the opinion of the Committee, wage-related WGA benefit is therefore beyond the scope of Convention no. 121. The Committee subsequently notes that entitlement to wage-related WGA benefit only arises if a partially occupationally disabled person meets the so-called eligibility requirement, meaning that in the 39 weeks (now 36 weeks) immediately prior to the date on which the right to WGA benefit arose, s/he worked for at least 26 weeks. With reference to Article 9, second paragraph of Convention no. 121, the Committee asks the Dutch government to further explain which benefit payments the eligibility requirement concerns and how the requirements should be understood.

In response hereto, it should firstly be noted that the eligibility requirement concerns wage-related WGA benefit exclusively. For the other benefit payments (IVA benefit, the WGA wage supplement and WGA subsequent benefit), no eligibility requirements apply. The eligibility requirement must be understood to mean that if it is complied with, a person who is partially unfit for work is entitled both to invalidity benefit and unemployment benefit. This can be explained as follows.

Following 104 weeks of illness, a partially occupationally disabled person will always be entitled to invalidity benefit, regardless of compliance with the eligibility requirement. If this last requirement has not been complied with, the person concerned is only entitled to invalidity benefit, namely the WGA wage supplement or the WGA subsequent benefit. If the eligibility requirement is met, the person concerned will be entitled both to invalidity benefit and unemployment benefit, specifically the wage-related WGA benefit. In other words, the last-mentioned benefit provides compensation for a loss of income as a result of occupational

disability as well as a result of unemployment. The eligibility requirement does not concern the question as to whether there is a right to WGA benefit, but only the sort of WGA benefit that the person is entitled to.

This does not substantively differ from the situation under the Invalidity Insurance Act (WAO). Then too, a person who was partially unfit for work was always entitled to an invalidity benefit, regardless of whether the eligibility requirement was complied with or not. If this last requirement was not complied with, the person concerned would have only have had a right to invalidity benefit, namely the WAO loss of income benefit or WAO subsequent benefit. If the eligibility requirement was complied with, the person concerned had both a right to invalidity benefit and unemployment benefit, therefore WAO benefit as well as WW benefit.

The difference between the WGA and the situation under the WAO is therefore that the wage-related WGA benefit is invalidity benefit and unemployment benefit combined. The sum of the wage-related WGA benefit is therefore equal to the sum of the WAO loss of income benefit and the WW benefit together. In other words, the WGA has not or has scarcely led to any substantive changes compared to the situation under the WAO.

This also applies to the duration of the wage-related WGA benefit. Under the WAO, the duration of the WAO loss of income benefit was generally one year shorter than the duration of WW benefit. In the WGA, the longest duration has been opted for. The duration of the wage-related WGA benefit is therefore equal to the duration of the WW benefit. This duration is dependent on the duration of the employment history and the age of the person concerned (employment history requirement). Furthermore, the duration of the WW benefit previously received is deducted from the duration of the wage-related WGA benefit. With regard to this duration, the Committee notes that on the grounds of Convention no. 121, it is not permitted to make benefit dependent on the duration of one's employment history or to reduce benefit payment by the duration of WW benefit previously received.

In connection herewith, supplementary to the foregoing, it should be noted that Article 9, second paragraph of Convention no. 121 determines that entitlement must not be made to depend on the duration of employment. The employment history requirement stipulated in the WGA is only of influence on the duration of wage-related WGA benefit, and not on the entitlement to benefit. Concerning the duration of the benefit, Article 9, third paragraph of Convention no. 121 determines that benefit must be granted for the period in which the employee is unfit for work. This condition is complied with in view of the fact that WGA is granted up to the age of 65 years, after which entitlement to AOW (old-age pension) arises.

More important is however the fact that as said, the duration of the wage-related WGA benefit is the result of the incorporation of the WW into the WGA. Regardless of the duration of his/her employment history, a partial occupationally disabled person is entitled to invalidity benefit up to the age of 65. If s/he complies with the conditions for entitlement to WW benefit, s/he will also be entitled to unemployment benefit. As stated above, this combined benefit is set out in the wage-related WGA benefit scheme. At the end of his/her entitlement, in the same way as a person who fails to comply with the eligibility requirement, the person concerned is entitled to invalidity benefit up to the age of 65, notably a WGA wage supplement or WGA subsequent benefit. It is therefore self-evident that the duration of the wage-related WGA benefit is equal to the duration of WW benefit. In the view of the Dutch government, the employment history requirement of the WGA is not therefore in breach of

Convention no. 121. The same applies to the reduction of the duration of WW benefit previously received. For the sake of completeness, it should be noted that the latter only applies if the person concerned was only insured on the grounds of the WIA Act because s/he was entitled to WW benefit. The underlying idea here is that in in this case, the right to WW benefit would have been restored if no right to WGA benefit had arisen. This too is substantively in line with the earlier situation under the WW/WAO.

In accordance with that requested by the Committee, the Dutch government assumes that sufficient further information has been hereby provided on the way in which the eligibility requirement should be understood.

d. The WGA wage supplement

Once wage-related WGA benefit has been discontinued or in the event that the eligibility requirement is not met, a person who is partially unfit for work will be entitled either to a wage supplement or a follow-up benefit. A wage supplement is generally higher than follow-up benefit. In order to qualify for a wage supplement, a person who is partially unfit for work must receive income from employment that is at least equal to 50% of his/her remaining earning capacity (referred to as the income requirement). The Committee is of the opinion that this income requirement is contrary to the basic philosophy of Convention no. 121, which guarantees a benefit payment at the level prescribed regardless of whether the residual earning capacity is utilised or not.

In response hereto, it should firstly be noted that on the grounds of the WGA, a partially occupationally disabled person receives a benefit payment that is higher than the minimum sum stipulated in Convention no. 121. On the grounds of Article 20, first paragraph of this convention, benefit in case of full occupational disability must amount to at least 60% of the statutory minimum wage. On the grounds of the third paragraph, in the event of partial occupational disability, benefit must be in reasonable proportion to that amount. These minimum standards are complied with at all times, as by and large, follow-up benefit is equal to 70% of the statutory minimum wage, multiplied by the occupational disability percentage. The WGA therefore guarantees a benefit that is higher than that prescribed on the grounds of Convention no. 121, regardless of whether the residual earning capacity is utilised or not. In other words, the WGA is not contrary to the basic philosophy of Convention no. 121. In the opinion of the Dutch government, in other respects too, the convention does not prevent a partially occupationally disabled person in employment from receiving a higher amount in benefit than a partially occupationally disabled person who does not work or works insufficiently.

e. WGA subsequent benefit

On the grounds of the WGA, among other things, a partially occupationally disabled person is obliged to attempt to a sufficient degree to obtain or keep suitable employment. In the view of the Committee, these obligations exceed that permitted on the grounds of Article 22 of Convention no. 121. According to the Committee, no sanctions can therefore be imposed in connection with the failure to comply with these obligations.

It is in itself correct that Article 22 of Convention no. 121 refrains from explicitly mentioning the possibility of imposing sanctions on an occupationally disabled person who fails to cooperate with his/her re-integration. However, the provisions of a convention must not be interpreted statically, but in line with social developments. It is completely accepted today that the partially occupationally disabled must do everything in their power to find work they

are capable of performing. Participation in the labour market is of equal or even greater importance than income protection. The UWV (Employee Insurance Agency) therefore offers people who are partially unfit for work support in finding a job. On the other hand, the partially occupationally disabled have their own responsibility to resume work. It is thereby appropriate to impose sanctions if the person concerned fails to cooperate with his/her re-integration.

f. The sum of the benefit payments

As set out above, by and large, the amount of the WGA subsequent benefit is 70% of the statutory minimum wage, multiplied by the percentage of occupational disability, while IVA benefit is 75% of the daily wage. The Committee notes that on the grounds of Article 14, third paragraph of Convention no. 121, benefit in case of partial occupational disability must be in reasonable proportion to benefit in case of full occupational disability. According to the Committee, the disproportionately low follow-up benefit leads to "hardship and poverty" for the partially occupationally disabled. In connection herewith, the Dutch government is requested to give a further explanation with regard to the amount of follow-up benefit that a recipient is entitled to.

In response to the foregoing, as set out above, it should be noted that as such, the amount of WGA subsequent benefit paid complies with the requirements of the convention. This is also not contested by the Committee. In view of this, it is unclear to the Dutch government why according to the Committee, the WGA subsequent benefit leads to "hardship and poverty".

The disproportionality between the WGA subsequent benefit and the IVA benefit cited by the Committee could also be nullified by lowering the amount of IVA benefit (and WGA benefit in case of full occupational disability), by relating this too to the statutory minimum wage, for example. The minimum standards of the convention would thereby be met. However, the Dutch government is not in favour of such action. In the opinion of the government, the benefits regime of the WIA gives both a high level of income protection (i.e. a higher level than prescribed by ILO 121) and a considerable incentive to continue to work as much as possible or to commence work insofar as is possible and as soon as possible. The Dutch government deems both principles to be of importance. The government has therefore expressed a preference for preserving the current WIA benefit structure, in view of the fact that as such, all benefits comply with the minimum standard of Convention no. 121 and the higher level of IVA benefit (and the WGA wage supplement) has a beneficial effect.

For the sake of completeness, it should be noted that the WGA subsequent benefit is not a sanction instrument. In relation to the higher level of the WGA wage supplement too, it forms an incentive that is geared to the resumption of work in keeping with the remaining capacity of theperson concerned, with due regard for his/her degree of occupationally disability.

V

Copies of the present report have been communicated to the following representative organisations of employers and workers:

- the National Federation of Christian Trade Unions (CNV)
- the Netherlands Trade Union Confederation (FNV)
- the trade union Federation for Middle and higher Level Employees (MHP)
- the Confederation of Netherlands Industry and Employers (VNO-NCW)