European Social Charter | Charte Sociale Européenne

02/11/2012 RAP/RCha/NL/VI(2013)

EUROPEAN SOCIAL CHARTER

6th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF THE NETHERLANDS

(Articles 3, 11, 12, 13, 14, 23 and 30 for the period 01/01/2008 – 31/12/2011)

Report registered by the Secretariat on 02 November 2012

CYCLE 2013

THE EUROPEAN SOCIAL CHARTER

The Netherlands' Sixth Report

for the period 1 January 2008 - 31 December 2011

Report

For the period 1 January 2008 to 31 December 2011, made by the Government of the Netherlands in accordance with Article C of the Revised European Social Charter, on the measures taken to give effect to the accepted provisions of the European Social Charter.

This report does not cover the application of such provisions in the non-metropolitan territories to which, in conformity with Article L they have been declared applicable.

In accordance with Article C of the revised European Social Charter, copies of this report have been communicated to:

- Netherlands Trade Union Confederation FNV
- National Federation of Christian Trade Unions in the Netherlands CNV
- Trade Union Federation for middle classes and higher level employees MHP
- Netherlands Council of Employers' Federations RCO

Contents

Article 3 – The right to safe and healthy working conditions

With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;
2. to issue safety and health regulations;
3. to provide for the enforcement of such regulations by measures of supervision;
4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.

Article 3§1

1) Please describe the national policy on occupational health and safety and the consultation with employers' and workers' organisations in formulating this policy. Please specify the nature of, reasons for and extent of any reforms.

No new developments.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the national policy in consultation with employers' and workers' organisations.

As mentioned in the previous report, the government supports the efforts of employers, employees, industries and sectors to implement national policy on occupational health and safety.

The following recent developments should be noted.

Dutch legislation provides that workplace hazards should be identified and assessed. The government, along with the social partners, developed a general basic tool for risk assessment. Subsequently, this basic tool was refined, sector by sector. In this way well over 100 specific digital risk assessment tools were created for use by companies in several sectors, especially small and medium-sized enterprises (SMEs). The basic tool has been used by the European Agency for Safety and Health at Work (EU-OSHA) in Bilbao to develop a tool for the EU, the Online interactive Risk Assessment (OiRA). Several EU countries have adapted OiRA to their specific needs and circumstances and are currently using it.

For a list of digital risk assessment tools covering a range of industries in the Netherlands, see www.rie.nl. Government has also worked with the social partners to find additional ways of encouraging use of these tools in small companies. As a result, government has financed the establishment of a Support Centre on Risk Identification and Assessment Tools (*Steunpunt ri&e-instrumenten*) to boost SME compliance. Besides providing facilities, government is promoting a culture that is supportive of the social partners' efforts to fulfil their responsibility.

A website, www.arboportaal.nl, has been set up to provide accurate and appropriate information on health and safety, which can be found from several different search angles. Collaboration with the social partners in the Labour Foundation (*Stichting van de Arbeid*) has resulted in about 150 health and safety catalogues, containing agreements between the social partners in specific sectors and industries on how best to tackle occupational safety and health (OSH) in these sectors. These catalogues cover more than half of the workforce in the Netherlands. They can all be downloaded at www.arboportaal.nl/types/alle/arbocatalogi?/onderwerpen.

In the Netherlands an Action Programme on Company Safety Culture (*Actieprogramma veiligheidscultuur in bedrijven*) is currently under way for the period 2010 to 2013. Basically, this is a safety awareness and safety behaviour campaign to prevent work-related accidents and to make safety an integral part of daily operations. The programme emphasises companies' responsibility. Its target is a 25% reduction in the number of accidents at participating companies, in line with the EU strategy to achieve a 25% reduction in accidents in the EU. The Action Programme is following up on one that lasted from 2003 to 2008, consisting of 22 pilot projects that proved the effectiveness of focusing on safety awareness and safety behaviour. The current programme is aimed at attaining the 25% target by disseminating knowledge and good practices from the earlier programme to a larger group of companies, especially SMEs. More information can be found on the website www.SamenVeiligWerken.nl.

Government has also supported the social partners' efforts to promote a policy on hazardous substances in the workplace. Employers are required by law to observe restrictions on the chemicals they use. Only specific substances that meet specific criteria are eligible for use within stipulated limits, in compliance with the EU Regulation on the Registration, Evaluation, Authorisation and Restriction of Chemical substances (REACH). The social partners, in collaboration with government, have developed a website (www.stoffenmanager.nl) with the aim of encouraging knowledge of and compliance with the restrictions, thus reducing health risks. The site has been online since the end of 2009.

In late 2011 the government initiated discussions on sustainable work and sent a letter to Parliament on the subject, with the aim of developing a programme on sustainable work and carrying it out in the years to come, starting in 2012. To enable more people to work longer, the government will also launch a joint programme with the social partners, the Ministry of Health and other stakeholders to support employers and employees. The programme will emphasise the need for regular training, education and mobility on the labour market, and action on better health and working conditions. Pilots will focus especially on health and working conditions in SMEs in health care, transport and the construction industry, by:

- communicating the need to take action on sustainable work;
- disseminating methods and practices to encourage healthy lifestyles and foster mental health while reducing work-related health risks and diseases due to work-related stress and those affecting the musculoskeletal system;
- supporting SMEs through workshops, master classes and targeted expert advice to companies.

3) *Please provide pertinent figures, statistics or any other relevant information, if appropriate.*

The state of workplace health and safety in the Netherlands is assessed every year and reported in the Health and Safety Review (*Arbobalans*). The most recent edition covers 2011 and can be found at www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2012/02/09/13.-arbobalans-2011.html. The survey includes figures on accidents at work. Figure 7.2 on page 147 gives figures which show that the risk of accidents resulting in injury has fallen over the long term, but appeared to be stable in the period 2005-2010. The survey also includes figures on various risks for workplace health and safety.

Employers are obliged to report serious accidents, especially those leading to hospitalisation, death or permanent damage to health. The most recent edition of the Monitor of Workplace Accidents in the Netherlands (*Monitor Arbeidsongevallen in Nederland*) dates from 2009: www.tno.nl/content.cfm?context=thema&content=prop_publicatie&laag1=891&laag2=904&laag3=74&item_id=849. This publication contains a variety of information on workplace accidents in the Netherlands. In 2009 218,000 employees were involved in an occupational accident resulting in injury and absence from work. About 4,300 occupational accidents resulted in hospitalisation and 85 workers were involved in a fatal occupational accident. In the period 2000-2009, the risk of a fatal accident decreased by 5.3% per year (by 39% over the whole period: see pp. 41-42 of the above report).

With regard to occupational diseases, the Netherlands Centre for Occupational Diseases (*Nederlands Centrum voor Beroepsziekten*, NCvB) produces an Alert Report every two years with the aim of providing useful information to policymakers. The report gives figures on and describes trends in the incidence of occupational diseases and their distribution among different sectors and occupations. Statistics from the NCvB identify issues requiring preventive measures or further research by policymakers and professionals working in workplace health and safety. Reports, statistics and other information can be found at www.occupationaldiseases.nl.

Article 3§2

1) *Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.*

One new provision should be mentioned: workers have acquired the right of information about their company's risk assessment.

2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework in consultation with employers' and workers' organisations.*

See the answer to Article 3§1, question 2.

Article 3§3

1) *Please describe the enforcement of safety and health regulations. Please specify the nature of, reasons for and extent of any reforms.*
2) *Please provide pertinent figures, statistics (for example Eurostat data) or any other*

relevant information on the number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardised accident rates per 100,000 workers; on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections; and on the number of breaches to health and safety regulations and the nature and type of sanctions imposed.

Remit of the health and safety inspectorate

Since January 2012 the Labour Inspectorate is part of the Social Affairs and Employment Inspectorate (I-SZW), whose remit extends to every place in the Netherlands where work is performed: 550,000 branches of companies and institutions, of which 80% have fewer than 10 employees. It also covers over 600,000 self-employed persons, who are required to comply with the provisions of the Working Conditions Act concerning major occupational hazards and risks to third parties. Administrative requirements (such as drawing up a risk assessment) and provisions on physical exertion and work-related stress do not apply to the self-employed.

A total of over 7 million working people are covered. In the Netherlands the Inspectorate also supervises the enforcement of health and safety legislation in the public sector, including prisons, the military and the police. The only exception is the raw materials extraction sector (natural gas and salt), where the State Supervision of Mines monitors compliance with the Working Conditions Act and Working Hours Act. The I-SZW also has agreements on cooperation with the Transport and Water Management Inspectorate and the Food and Consumer Product Safety Authority in parts of the transport sector (shipping, aviation and rail and road transport) and in the hospitality business.

Overview of health and safety at work in the Netherlands

Data gathered at European level show that Dutch employees assess their working conditions more positively than employees elsewhere in the EU. Sector-by-sector comparisons also show relatively favourable results for the Netherlands. In the most demanding sectors, like manufacturing and construction, employees in the Netherlands report fewer physical occupational hazards than in other European countries. The Netherlands also scores relatively well on work-related stress. (See e.g. Eurofound, *Fifth European Working Conditions Survey* (Luxembourg: Publications Office of the European Union, 2012), ISBN 978-92-897-1062-6.)

Monitoring compliance with health and safety legislation

The Inspectorate's activities and inspection projects focus on industries and companies that risk assessments identify as high-risk and low-compliance. Consequently, the impression given by these inspections is less favourable than the statistical averages.

The Inspectorate's Health and Safety Risk Assessment Model (*Arbeidsinspectie Risicomodel Arbeidsomstandigheden,* AIRA) is used to target industries and companies where the most occupational hazards can be anticipated. In drawing up its inspection programme, with a mix of industries and objects to be inspected, the Inspectorate supplements the AIRA with its experience during inspections and monitoring and the views of policymakers and the social partners. The inspection programme and the inspection schedule based on it are then submitted to the Minister of Social Affairs and Employment for approval. Accidents and complaints are also investigated and monitoring investigations conducted.

Of the Labour Inspectorate health and safety inspections in 2008, 56% led to interventions. This percentage has been hovering around 55% for many years. In 15% of cases the intervention consisted of an 'incentive letter', a form of intervention introduced in 2007.

There has been a gradual trend towards more frequent satisfactory results of repeat inspections. Only 2% of checks on the implementation of agreements led to a fine or another major sanction. Over the five-year period from 2003 to 2008, the percentage of interventions following repeat inspections fell steadily from 6% to 2%.

The Labour Inspectorate imposed somewhat fewer fines in 2008 than in previous years, though the fines it did impose were higher. The average fine almost doubled from 2006 to 2008, while total fines for infractions of the Working Conditions Act and/or Working Hours Act rose from €5.3 million in 2006 to €6.8 million in 2007 to €9.8 million in 2008. The 5% decrease in the number of fines imposed is due to more flexible rules on risk identification and assessment for smaller companies. The higher average fines reflect revised rules, based on the principle: ‘strict where necessary, mild where possible’.

The economic crisis dominated the headlines in 2009. Despite the decrease in construction, however, the Labour Inspectorate suspended work due to acute danger more often, and the percentage of interventions following inspections increased somewhat. The Inspectorate received significantly more health and safety complaints and more reports of accidents than in earlier years.

Fortunately there was a great deal of good news in 2009 as well. First and foremost, the social partners stepped up their efforts to create the conditions at sectoral level for safe, healthy and decent work. More intensive information campaigns around inspection projects also yielded good results.

In 2009 the Labour Inspectorate inspected 21,386 companies for compliance with the Working Conditions Act, Working Hours Act and Nuclear Energy Act. It also investigated 2,416 workplace accidents, 76 of them fatal, and 1,358 complaints concerning occupational health and safety or working hours: more than had been anticipated in the annual plan for 2009. The number of accidents reported was 10% higher in 2009 than in 2008, while the number of complaints received was 40% higher. Fortunately, the number of reported fatal accidents was 13% lower than the year before. The Inspectorate took enforcement action in response to 58% of the accident reports, slightly more than in previous years.

Repeat inspections showed in 98% of the cases that the problems had been resolved. The number of occasions on which work was suspended due to acute danger rose by 6%, from 2,248 in 2008 to 2,372 in 2009, and the number of administrative fines rose by 37%, from 1,919 in 2008 to 2,623 in 2009. The amount collected rose from €9.8 million to €13.9 million – though these figures give a distorted picture, as the Labour Inspectorate managed in 2009 to sharply reduce its backlog in imposing and collecting fines.

In 2010 working conditions in the Netherlands in general showed a positive trend compared with other European countries, but not all indicators pointed in the right direction. The Labour Inspectorate together with other stakeholders faced the challenge of reversing the increased number of workplace accidents and preventing occupational diseases by, amongst other things, improving working conditions,, despite the socioeconomic difficulties that the Netherlands, like other countries, is experiencing. With regard to trends in compliance with the Working Conditions Act, the Working Hours Act, the Nuclear Energy Act and the Commodities Act, the Inspectorate’s figures from monitoring companies’ health and safety policy and sickness absence policy showed a mixed picture. In 2010 a gradual downward

trend was noted in compliance with key provisions of policy concerning safety, health and sickness absence.

The Labour Inspectorate increasingly took enforcement action after inspections: the percentage of cases in which action was taken rose from 56% of inspected companies in 2008, to 58% in 2009 and 61% in 2010. This reflects a combination of more targeted inspections and declining compliance. As in earlier years, 98% of companies had resolved the problems when repeat inspections were conducted, showing that the Inspectorate's enforcement measures still produce satisfactory results. The Inspectorate initiated inspections itself in 18 priority sectors, in close consultation with the social partners. As many companies as possible in these sectors received informational brochures on the forthcoming inspections, so that they knew how and why inspections would be done.

The Inspectorate's specific thematic programmes in 2010 concerned accident reduction, dealing with hazardous substances, and aggression and violence against employees dealing with the public. Besides targeted inspections, these programmes relied heavily on information campaigns. In the accident reduction programme, for example, the Inspectorate worked actively with the vocational education sector to formulate teaching objectives and to integrate workplace safety into syllabuses. In the hazardous substances programme, the Inspectorate worked to support companies' use of safety data sheets and their compliance with the EU REACH Regulation. The Inspectorate also worked with companies on applying the precautionary principle to still unknown or uncertain risks, as in nanotechnology.

In 2010 the Labour Inspectorate initiated 18,541 inspections under the Working Conditions Act, Working Hours Act, Nuclear Energy Act and Commodities Act, and investigated 2,111 accidents and 1,263 complaints.

In 2011 enforcement instruments were used 12,030 times to put an end to infractions as quickly as possible. Failure to comply with the demands or warnings in an enforcement instrument can lead to the imposition of a fine. A 'warning' refers to an existing regulation that is considered to be generally known; in a 'demand', the Inspectorate itself formulates the specific requirement. Before 2011 there were administrative rules elaborating many regulations in detail, and when the Inspectorate referred to such a regulation it did so in the form of a warning. Since 2011 most of these administrative rules have lapsed, so the Inspectorate can no longer refer to them but has to formulate the specific requirement in the form of a demand. As a result the Inspectorate issued more demands in 2011 than in 2010 and fewer warnings.

In 2011 1,627 fines were imposed: 1,581 for infringements of the Working Conditions Act and 46 for infringements of the Working Hours Act. The number of fines for infringement of the Working Hours Act declined in 2011 because transport inspection and monitoring had been transferred to the Human Environment and Transport Inspectorate. In 2011 12,000 inspections and 2,638 monitoring investigations were conducted and 2,094 accident reports and 1,648 complaints investigated.

Specific focuses

In addition to its regular inspections on the basis of risk assessments, in recent years the Inspectorate has started to conduct inspections in specific focus areas as part of the sectoral approach.

Focus: Asbestos
In 2011 asbestos was one of the spearheads of the Inspectorate's work. The spearhead had three major components: inspections at certified companies, tracking down rogue clean-up companies, and collaboration with other supervisory authorities.

Accident prevention programme
The Inspectorate worked in 2011 with the Workplace Health and Safety Department and the social partners to step up efforts to reduce the number of accidents. This programme consisted of inspections, campaigns aimed at young people, and measures to encourage self-inspection.

Programme on working with hazardous substances
Work is done with hazardous substances at about one in three Dutch companies. This multi-annual programme for 2010-2014 had three components in 2011: inspections, support for self-inspection, and REACH.

Focus: aggression and violence against employees dealing with the public
Aggression and violence were another spearhead of the Inspectorate's monitoring activities in 2011, and were highlighted in both inspections and information campaigns. The spearhead activities had three components in 2011: inspections, support for self-inspection, and a smartphone app for reporting incidents. In many organisations the barriers to reporting aggression are still too high. The Inspectorate therefore began in 2011 to develop an app for smartphones. The demo version was enthusiastically received in the sectors concerned.

Focus: the Nuclear Energy Act
In 2011 200 inspections were conducted at hospitals, road construction firms and other companies that work with radioactive material, and at all companies and institutions with a consolidated permit. Almost a quarter of the facilities inspected were in full compliance with the Nuclear Energy Act. Violations concerned one or more sources of moderately radioactive material at companies that had forgotten to comply with one or more of their obligations under the Act. The results of the inspections will be published in 2012.

Market supervision – product legislation
The Inspectorate's supervision of the market to ensure compliance with product legislation (the Commodities Act and Commodities Act Decrees) covers the following categories of professional products: machines, personal protection equipment, containers, lifts, pressure equipment, and equipment intended for use in potentially explosive atmospheres. The Inspectorate's activities in this field in 2011 involved investigations of accidents involving unsafe products, of complaints, and of foreign and domestic danger signs.

Assessing health and safety catalogues
The social partners began work in 2008 on producing health and safety catalogues, in which they indicate how the statutory norms will be upheld in their sector. The Inspectorate uses the catalogues as reference points for its enforcement policy and supports the catalogues' implementation through its sectoral approach.

In 2007 only six catalogues were submitted to the Labour Inspectorate for assessment, but by the end of 2008 there were 39. The Inspectorate assessed 30 of them in 2009, 28 of which were approved as a whole or in part and two rejected. The Inspectorate's assessment of health and safety catalogues got well under way in the second half of 2009; by the end of 2009 49%

of the Netherlands' workforce was covered by a catalogue, and 158 catalogues had been submitted for assessment. Many of these catalogues will have to be supplemented in the next several years, as they do not cover all the risks existing in their sector. The number of catalogues increased further in 2010, so that 51% of employees were covered by a catalogue by the end of the year; the target for 2010 had been 60%.

The sectoral approach
The revised Working Conditions Act entered into force on 1 January 2007. At the heart of the revised Act is a greater role for the social partners in identifying the measures that companies can take to comply with the statutory norms. The Inspectorate has been adapting to this modus operandi with a renewed sectoral approach, with brochures and with a 'new inspection philosophy', which entails a tailored approach at sectoral, industry and company level. Assessments of risks and enforcement determined the priority to be given to a number of sectors, in which a range of instruments will be deployed for several years to enhance enforcement and promote self-motivation by companies and the social partners in tackling health and safety issues.

The sectoral approach also implies responding to measures taken by the social partners in these sectors and industries. The more actively these parties are engaged in promoting compliance with the legislation, the fewer inspections will be conducted. For specific inspection projects the Inspectorate is using sectoral brochures: informational material setting out the key risks and statutory targets for the sector. This focuses attention more sharply on the points that are essential to compliance in a particular industry or sector. By the end of 2008 32 of these brochures were available.

Cooperation between inspectorates on health and safety issues
Cooperation has been and is being sought with other central government inspectorates on health and safety issues. In 2008 an effort was made to establish several joint front offices, notably for the hospitality business, metalworking and construction. We are trying as much as possible to offer the employers one-stop monitoring, through either physical or virtual shared locations. In 2008 the Food and Consumer Product Safety Authority (VWA) carried out a Holiday Work Inspection Project for the Labour Inspectorate in the hospitality business. The Inspectorate is now working with the VWA to develop a joint strategy for market supervision in areas where both agencies have supervisory tasks.

The State Supervision of Mines has been monitoring health and safety conditions in extractive industries for much longer than the new combined Inspectorate. In the field of health care, the Laour Inspectorate has conducted joint risk assessments and drawn up joint annual plans with the Healthcare Inspectorate. Under the direction of the Inspection Council, it is also contributing to several projects and developments aimed at reorganising the monitoring process and thus reducing the perceived burden of inspections.

Staffing levels
For the task of monitoring occupational health and safety and working hours and rest periods, the Labour Inspectorate had at the end of 2008 249 FTE inspector posts, roughly the same number as the year before. It had about 22 project leaders and project secretaries for the sectoral approach, and about 36 specialists from various disciplines to support the inspections and the sectoral approach. In 2009 there were 230 inspectors for health and safety and 40 for major hazard control (MHC); in 2010 there were 218 inspectors for health and safety and 42

for MHC; and in 2011 the number of inspectors had declined further to 203 for health and safety and 35 for MHC, as a result of political decisions on cutbacks.

Article 3§4

1) *Please describe the occupational health services. Please specify the nature of, reasons for and extent of any reforms.*

No new developments

2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.*

The only new development is that the government has funded the establishment of a Support Centre on Risk Identification and Assessment Tools (*Steunpunt ri&e-instrumenten*) in order to develop, in cooperation with OSH experts, even more user-friendly digital tools than the existing ones. These tools are expected to be ready in 2012.

3) *Please provide pertinent figures, statistics or any other relevant information, if appropriate.*

There are no new developments in this field. However, www.arbo-advies.nl contains a list of certified external OSH services in the Netherlands, and www.zorgkaartnederland.nl/arbodienst gives the names of internal and external OSH services.

Questions from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

Paragraph 1

a. *The Committee asks that the next report provides information on how occupational risk prevention is incorporated at all levels and form part of other public policies (on employment, persons with disabilities, equal opportunities, etc.)..*

Occupational risk prevention is an integral part of Dutch OSH legislation, the existing system of OSH services all over the country, the services available from OSH experts, and the work of the I-SZW and other inspectorates monitoring occupational diseases and accidents. A range of tools (such as risk assessment tools, health and safety catalogues and a website on hazardous substances) are designed to support the social partners' efforts. Moreover, a programme currently under way on sustainable employability and active ageing links the work of several ministries (including the Ministries of Social Affairs & Employment, Health, Education and Economic Affairs) and the social partners in a concerted effort to ensure that workers are active and in good health as they reach retirement age, thus broadening employment opportunities for all kinds of workers. See also the answer under article 3§3.

Paragraph 2

b. *The Committee asks that the next report gives an update of all relevant regulations on safety and health at work.*

The relevant regulations can be downloaded at nl.osha.europa.eu/fop/netherlands/en/legislation/index_html.

Paragraph 3

c. *The report indicates that in 2007 the Labour Inspectorate carried out almost 20 000 inspection visits. The Committee asks that the next report provides the proportion of workers covered by inspection visits.*

The Inspectorate inspects approximately 20,000 companies each year with about 300,000 employees. This amounts to around 4.5% of the roughly 7 million people in the Dutch workforce.

Paragraph 4

d. *The Committee asks for further information on what must be provided internally in case an enterprise chooses not to have recourse to external services. In this regard it also requests information on employees' access to occupational health doctors.*

On the basis of the risk assessment, an employer decides how to organise a health and safety service for the enterprise, either with an external service or in-house. In the latter case the employer is obliged to have support from one or more expert employees. At the minimum, the employer is required to provide medical examinations when an employee is appointed, arrange regular occupational health screening, and have a contract with a qualified occupational health doctor for sickness counselling.

As for accessibility, as stated above, the Netherlands has a nationwide system of health and safety services. A list of in-house health and safety services was included in our previous report. The present report includes (in the answer to question (3) under article 3§4) links to

www.arbo-advies.nl, containing a list of certified external OSH services in the Netherlands, and www.zorgkaartnederland.nl/arbodienst, with the names of internal and external OSH services.

Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Article 11§1

1) Please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Public Health Act (WPG)

In 2008 the Public Health Act replaced three pieces of legislation in this area: the Public Health (Preventive Measures) Act, the Infectious Diseases Act and the Quarantine Act. Most amendments concern infectious disease control. The previous report, covering the period from 1 January 2004 to 31 December 2007, described the legislative changes and their main repercussions. These mainly relate to the tasks and responsibilities of the Minister of Health, Welfare and Sport and of the mayor, the changes concerning the duty to report infectious diseases and the special status accorded to entry points, i.e. ports and airports.

The Public Health Act was amended again in 2011, establishing a statutory relationship between crisis management in two areas: public safety and health care. This applies both at regional level (the regions are now all on an equal footing) and in substantive terms (there is just one public health director, who has ultimate responsibility during an emergency and at other times). A statutory relationship has also been established between the public health policy of central and local government, in terms of both timescales and content.

The islands of Bonaire, St Eustatius and Saba (the Netherlands in the Caribbean) acquired special status modelled on that of a municipality on 10 October 2010 and were accordingly specifically added to the Public Health Act.

National prevention policy

In 2008, the government published a policy document on health and prevention entitled *Being healthy and staying health*. The four main areas addressed were: 1. stakes, responsibilities and forms of prevention; 2. the association between setting and behaviour; 3. the association between preventive and curative care; and 4. integration, cooperation and modernisation in the administrative setting.

In 2011 the government published a national health policy document entitled *Health close to people* as a follow-up to its 2006 preventive policy document. The priorities in the latter document, i.e. obesity, diabetes, depression, smoking and alcohol abuse, are still important but the way in which they are tackled has significantly changed. The government has opted for a positive approach and is working with local authorities, sports clubs and the private

sector with the aim of giving people more opportunities to keep fit and active safely and in their local community. Exercise and physical activity were added as priority in the 2011 document.

The emphasis is on individuals and the environment in which they work, rest and play. The business community, civil society organisations, the education sector and care providers will play a larger role in promoting a healthy lifestyle, with the key being to facilitate access to healthy choices. The Dutch government will contribute to achieving this goal in various ways.

If people are to take responsibility for their own health, they need to have access to a high-quality healthcare service that can deal with all their questions and problems. Possible options include easily identifiable and accessible facilities available in the community or online (eHealth).

The government is directly responsible for population screening, and has now decided to introduce colorectal cancer screening.

The government is also focusing particular attention on young people, not only promoting a healthy lifestyle, identifying risks at an early stage and directing efforts at encouraging resistance to the temptations of everyday life, but also setting boundaries, for example by making the possession of alcohol a criminal offence for under-16s.

The principles and proposals set out in the policy document will be implemented over the next few years.

There were no major developments in efforts to combat HIV/AIDS between 2008 and 2011. STD clinics did introduce HIV testing as standard in January 2011, based on the opt-out principle, which means that clients are always tested unless they specifically withhold consent.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

The policy themes outlined above have been developed by the Ministry of Health, Welfare and Sport at national and/or local level. Below are a few examples of current projects, bills and action plans to illustrate how this policy is being implemented.

Nurture and innovate

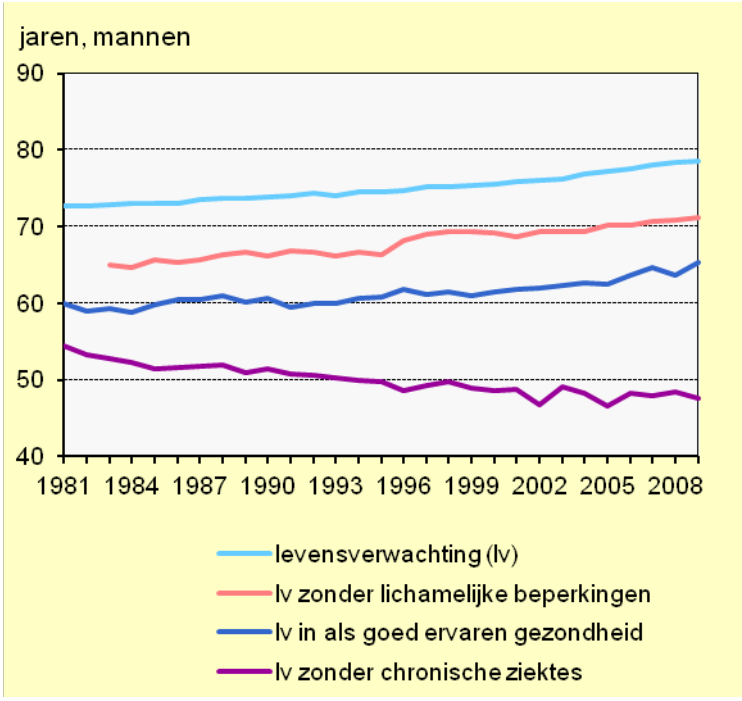
- A framework paper on screening has been issued, stating the government's view that products used to test health should meet minimum quality requirements. There should also be reliable information available on medical screening. Within the European Partnership for Action against Cancer (EPAAC) a joint action to obtain consensus on 'quality criteria for health checks' has started.
- The population screening programmes (e.g. breast cancer, cervical cancer, neonatal screening) are very successful, though new technologies offer opportunities for further improvement. In 2011 the Minister of Health announced the start of a population screening programme for colorectal cancer in 2013.
- The essence of youth health care is to monitor the development of young people and respond promptly to any warning signs. Since 2008 youth healthcare services have been increasingly provided through special youth and family centres, which offer

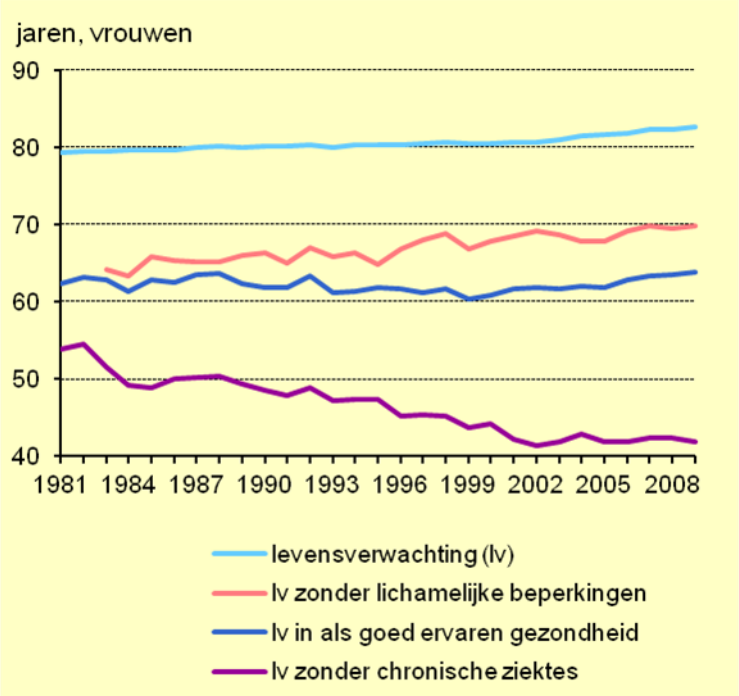
comprehensive parenting support. Local authorities have been tasked with making local youth policy more cohesive, for example by ensuring better collaboration with schools. Multidisciplinary pupil support advisory teams have been set up in nearly all schools to discuss any children giving cause for concern so that they can get the help they need quickly.

- During the reporting period, paper youth healthcare records were digitised. Since 1 July 2010 there has been a statutory requirement to keep electronic records of new patient data in the area of youth health care. The aim is to enhance the quality of youth health care, improve the transfer of records and enable risks to be identified more quickly. As of the end of 2011, all youth healthcare organisations – bar one – were working completely or partially with electronic records.

3) Please supply any relevant statistics or other information on the main health indicators and on health services and professions (for example WHO and/or Eurostat data).

People in the Netherlands are living longer and longer. The table provided by the National Institute for Public Health and the Environment (RIVM) (see below) reveals that the gain in life expectancy over the past 25 years is usually offset by illness in later years. Life expectancy free of chronic illness for men and women in the Netherlands has even fallen to 48 and 42 respectively, a decrease of four to nine years during this period. As of 2008, the average Dutch woman lives almost half of her life with a chronic illness. (In this context, a chronic illness is understood to mean an irreversible ailment lasting a relatively long time, with no prospect of a full recovery, and requiring long-term health care.) However, this does not mean that the health of the Dutch population has seriously deteriorated. There is also good news: since 1983 Dutch people have gained an average of five years of life without any physical disability, and 2½ years in perceived good health, which more or less corresponds to the increase in life expectancy (four years). These additional years are therefore predominantly free of physical disability and in perceived good health. So although there are a growing number of people with an illness, generally speaking Dutch people are not perceptibly less healthy. The apparent contradiction lies in the development of objectively demonstrable illnesses on the one hand and subjectively perceived physical impairments and health status on the other. Consequently, more illnesses does not automatically mean less healthy.





Years, men/women
Top line: life expectancy (LE)
Second line: LE without physical disability
Third line: LE in perceived good health
Forth line: LE without chronic illness

Source: J. Polder, S. Kooiker, F. van der Lucht, 'De gezondheidsepidemie. Waarom we gezonder en zieker worden?' Amsterdam: Reed Business b.v., 2012

Life expectancy

	men life expectancy (LE)	women life expectancy (LE)	men LE without fysical disability	women LE without fysical disability	men LE in perceived good health	women LE in perceived good health	men LE without chronical illness	women LE without chronical illness
1981	72.71	79.32			59.9	62.4	54.5	53.9
1982	72.75	79.44			59,0	63.1	53.3	54.5
1983	72.93	79.56	65	64.2	59.3	62.8	52.7	51.5
1984	72.96	79.67	64.6	63.3	58.8	61.4	52.2	49.2
1985	73.07	79.66	65.7	65.8	59.8	62.9	51.4	48.8
1986	73.09	79.61	65.3	65.3	60.5	62.5	51.6	50,0
1987	73.51	80.06	65.6	65.2	60.5	63.5	51.8	50.1
1988	73.69	80.24	66.3	65.1	61	63.6	52	50.3
1989	73.67	79.93	66.7	66,0	60.2	62.3	50.9	49.3
1990	73.84	80.11	66.1	66.4	60.6	61.9	51.4	48.5
1991	74.05	80.15	66.9	65,0	59.4	61.9	50.7	47.9
1992	74.30	80.28	66.6	67,0	60,0	63.3	50.6	48.8
1993	73.98	80,00	66.1	65.9	59.9	61.1	50.2	47.1
1994	74.58	80.31	66.7	66.3	60.7	61.4	49.9	47.4
1995	74.59	80.36	66.3	64.9	60.8	61.9	49.8	47.3
1996	74.66	80.35	68.1	66.8	61.8	61.7	48.6	45.2
1997	75.17	80.55	69	68,0	61.1	61.2	49.3	45.3
1998	75.19	80.69	69.3	68.9	61.4	61.6	49.7	45.2
1999	75.34	80.45	69.3	66.9	60.9	60.4	49,0	43.7
2000	75.54	80.58	69.2	67.8	61.5	60.9	48.6	44.2
2001	75.80	80.71	68.7	68.5	61.8	61.6	48.7	42.1
2002	75.99	80.69	69.4	69.2	62,0	61.9	46.8	41.3
2003	76.23	80.93	69.4	68.6	62.4	61.6	49.1	41.8
2004	76.87	81.44	69.3	67.8	62.6	62,0	48.3	42.9
2005	77.19	81.60	70.2	67.8	62.5	61.8	46.6	41.9
2006	77.63	81.89	70.2	69.2	63.6	62.9	48.3	41.8
2007	78.01	82.31	70.7	69.9	64.7	63.4	47.9	42.3
2008	78.32	82.28	70.9	69.5	63.7	63.5	48.4	42.4
2009	78.53	82.65	71.2	69.9	65.3	63.8	47.6	41.8
delta	5.39	2.72	5.9	5.3	4.4	0.7	-4.3	-9.1
	4.055		5.6		2.55		-6.7	

Article 11§2

1) For States that have not accepted paragraph 1, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Not applicable.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

No new developments.

3) Please supply any relevant statistics or other information, including on consultation and screening services in schools and for the rest of the population.

Youth health care is preventive health care for children and young people up to the age of 19. The aim is to reach everyone in this age group. More than 95% of very young children (up to age four) make use of youth healthcare services, with the figure ranging from 80% to over 95% among school-age children, where regional differences are more pronounced.

Article 11§3

1) *For States that have accepted neither paragraph 1 nor paragraph 2, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.*

Not applicable.

2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.*

No new developments.

3) *Please supply any relevant statistics or other information on the percentage of smokers in the general population, trends in alcohol consumption and the rates of vaccination cover for infectious and epidemic diseases.*

Tobacco

Smoking has been banned in restaurants, cafés, bars, clubs and other catering establishments since 1 July 2008. However, this prompted a great deal of controversy among owners of smaller businesses, who complained that, unlike large businesses, they did not have the resources to create a separate smoking area. The result is that the two cannot compete on a level playing field. When a new government came to power in October 2010, it was therefore decided to make an exception to the smoke-free rule for establishments with premises of less than 70 m^2 and no staff, with effect from June 2011. The current legislation can be consulted (in Dutch) at:
http://www.rijksoverheid.nl/onderwerpen/roken/documenten-en-publicaties/kamerstukken/2010/12/17/ontwerpbesluit-houdende-wijziging-van-het-besluit-uitvoering-rookvrije-werkplek-horeca-en-en-andere-ruimten.html

In addition, fines for violating the smoking ban have doubled since it was first introduced in 2008, in order to act as a greater deterrent to establishments that are not covered by the exception and thus ensure better compliance.

Alcohol

The government has introduced a bill amending the Licensing and Catering Act, which is currently before the Senate, with a view to lowering alcohol consumption, especially among young people, preventing alcohol-related public order offences and reducing the administrative burden.
http://www.europa-nu.nl/id/vi7781ejulz8/32022_wijziging_van_de_drank_en

By simplifying the licensing procedure under the Act, the bill will reduce the administrative burden on volunteers and companies, and will also give local authorities more scope to combat alcohol abuse among young people.

The bill will give local authorities the power, on an experimental basis, to close the spirits section of supermarkets if they are caught selling alcohol to juveniles under the age of 16 three times in one year. Furthermore, under-16s will not be allowed to carry any alcoholic beverages on public thoroughfares or in areas open to the public, even at specific times and even if an entrance fee is applicable or access is restricted.

TRENDS

Tobacco

Statistics show a continuing downward trend in the number of smokers, among both adults and young people. In 1958, 60% of the Dutch population smoked occasionally, the figure reaching as high as 90% among Dutch men. By 2011, 25% of Dutch people aged 15 and over smoked on occasion, 27% of men and 23% of women. The percentage of smokers is significantly lower among the over-65s and young people.
http://www.stivoro.nl/Upload/Feiten%20en%20cijfers/Trendpublicatie%20Percentage%20Rokers%202011.pdf

The number of young smokers is also showing a downward trend: 20% of 10 to 19-year-olds reported smoking regularly in 2011, i.e. they said 'yes' when asked whether they had smoked in the past four weeks. The percentage of boys and girls who have smoked in the past four weeks is virtually identical (21% of boys and 20% of girls). Only a few boys younger than 13 have smoked, but 1 in 3 aged 16 and over have smoked in the past four weeks.
http://www.stivoro.nl/Upload/Feiten%20en%20cijfers/Fact%20sheet%20RJM%202011.pdf

NB In future, the monitor will come under the responsibility of the Netherlands Institute of Mental Health and Addiction (Trimbos Instituut), which may mean that the links to the above factsheets will change.

Alcohol

There is a downward trend in alcohol consumption among young people. In 2003, 84% of juveniles under 16 had drunk alcohol, dropping to 66% in 2009. In 2003, 55% had drunk alcohol in the past month, compared with 37% in 2009. Binge drinking is still a cause for concern, with two-thirds of recent drinkers consuming more than five glasses of alcohol in one session in the past month, and 9% more than ten glasses.
http://www.stap.nl/nl/home/feiten-en-cijfers.html

Drugs

Cannabis

The percentage of current cannabis users in the general population aged 15-64 increased between 2001 and 2009. In 2005, 3.3% (i.e. 363,000 people) were current users, rising to 4.2% in 2009 (466,000). There has been a steady increase in the number of clients seeking addiction treatment for a cannabis problem. Between 2000 and 2010 the number of primary cannabis clients rose from 3,500 to 11,000. Almost two-thirds of cannabis clients (65%) are 25 and over. Few people are admitted to general hospitals with cannabis problems as the primary diagnosis (75 admissions in 2009). The number of admissions with cannabis abuse and dependence as the secondary diagnosis is larger and rose from 377 in 2006 to 520 in 2009. This trend may indicate an increase in the number of problem users of cannabis, but may also reflect an improvement in the treatment available, or else a growing awareness of the addictive potential of cannabis, possibly prompting users to seek help sooner.

Cocaine
Current use of cocaine in the general population aged 15-64 increased between 2005 and 2009 (in 2005: 0.3%, or 32,000 users; in 2009: 0.5%, or nearly 50,000 users). Among juveniles and young adults in social settings, cocaine use (mainly snorting) is considerably more prevalent than in the general population. Cocaine is used not only in the social scene, but often at home, both at the weekend and during the week. The popularity of this drug has now spread to all parts of the Netherlands, although – as in Amsterdam – saturation point seems to have been reached. There may have been a further rise in cocaine use among rural youth. Cocaine combined with alcohol continues to be the stimulant of choice. Among hard drug addicts, cocaine in the form of crack, which is smoked and is much more addictive, has become an established part of their drugs repertoire. Crack use occurs relatively seldom among problem juveniles. However, it is not known how many people suffer physical, mental or social problems on account of excessive cocaine use. Data from addiction treatment services registered a sharp rise in the number of primary cocaine clients from 2,500 in 1994 to 10,000 in 2004, but this trend did not continue. Between 2005 and 2009 the number of cocaine clients remained steady at 10,000, before dropping by 5% to 9,500 in 2010, mainly due to a decrease in the number of clients with a primary crack problem. The number of hospital admissions involving cocaine showed an upward trend until 2002 and has fluctuated around the same level since then. In 2006 there were 514 admissions with cocaine abuse and dependence as the secondary diagnosis, and 637 in 2009. Cocaine problems as the primary diagnosis occur much less frequently (90 admissions in 2006 and 100 in 2009).

Amphetamines
In the general population aged 15-64, amphetamine use is relatively low and stable. In 2009 the percentage of current amphetamine users was 0.2%, or 21,000 people. Nonetheless, the number of amphetamine/ecstasy users seeking addiction treatment increased from 482 in 2001 to 1,805 in 2010. The proportion of amphetamine/ecstasy users as a percentage of total treatment demand for drug problems is still low (2% in 2010). The number of general hospital admissions related to amphetamine-like substances is low, though 2004 saw a momentary rise in the number of secondary diagnoses in connection with amphetamine-like substance dependence and abuse (63 in 2003, 88 in 2006 and 127 in 2009).

Opioids
According to the most recent estimates dating from 2010, there were around 18,000 problem opiate users in the Netherlands in 2008. The age profile of Dutch opiate users has grown steadily older over the years. Between 2001 and 2010 there was also a drop in the total number of clients with a primary opiate problem, from almost 18,000 to 12,000 (-22%). In 2010 only 4% of opiate clients sought help with a drug problem for the first time. The rest were already registered with the addiction treatment services. There was also a downward trend in the number of general hospital admissions with opiate problems as the secondary diagnosis: 674 and 580 in 2002 and 2010 respectively, a decrease of 20%. The remaining group of opiate clients is growing older and often has to contend with physical and mental problems. The decrease in the percentage of current opiate-injecting clients registered with the addiction treatment services levelled off in 2010 at 10%. New HIV diagnoses among injecting hard drug users are now rare. Injecting is still a significant risk factor for hepatitis C infection. The percentage of hepatitis C infections among registered HIV-positive injecting drug users is particularly high.

The 2010 National Drug Monitor provides facts and figures on the use of drugs, alcohol and tobacco (http://www.trimbos.nl/webwinkel/productoverzicht-webwinkel/feiten---cijfers---

beleid/af/af1106-ndm-annual-report-2010). The above is a summary of the findings with regard to drugs.

Vaccination coverage against infectious diseases

The rate of vaccination coverage for most vaccines in the Netherlands is over 95%. As a result, the national immunisation programme is highly effective. Participation in this programme is voluntary (RIVM). The vaccination programme for the vaccine against human papillomavirus (HPV) in girls aged 11 got off to a rather difficult start but vaccination rates are now rising.

Questions from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

Paragraph 1

a. *The Committee has stated that conditions in hospitals, including psychiatric institutions and other care centres, must be adequate and preserve human dignity (Conclusions XVII-2 and 2005, statement of interpretation of Article 11, §5; Conclusions 2005, Romania). It asks for information in the next report on patients' living conditions in hospitals, including psychiatric institutions and other care centres.*

With regard to legislation designed to preserve human dignity, two bills are currently before Parliament, one on consumer rights in health care and the other relating to care provided under the exceptional medical expenses scheme. The first bill is intended to replace existing legislation, giving healthcare clients explicit rights and strengthening their position, whilst ensuring a higher standard of health care. Healthcare clients, including those requiring long-term care or mental healthcare services, will be entitled to consultation about their options, giving them the opportunity to specify their needs and discuss the most appropriate treatment with a care provider. They will then be in a position to give fully informed consent to treatment. Without this consent, treatment cannot proceed (save in exceptional cases). All clients will be entitled to access their own medical records, to have a declaration appended or to have parts of their records destroyed (save in exceptional cases). Third parties will be able to inspect medical records only with the client's consent. Clients will be entitled to receive information about anything that goes wrong in the provision of care. Their privacy must also be guaranteed. These are all aspects relevant to human dignity.

As regards care provided under the exceptional medical expenses scheme, the second bill mentioned above elaborates further on the proposed consultation about care. Clients who have been receiving care under this scheme for longer than three months will be entitled to regular discussions about their healthcare plan, during which specific goals, responsibility for care, and coordination between care providers will be agreed. In the case of clients in an approved institution, agreements must also be made on nine aspects of daily institutional life. Throughout the process, the primary focus will be on how clients wish to organise their own lives, with the aim of ensuring that they retain as much control as possible. The aspects covered will include hygiene, eating and drinking, living environment, daily activities, staff-client interaction, and religion or beliefs. Self-determination and human dignity will be the guiding principles at all times.

Human rights and human dignity are important topics in the context of compulsory admission to a psychiatric institution. The Psychiatric Hospitals (Committals) Act (BOPZ) defines the rights of patients in this situation and stipulates the requirements regarding admission. Two new Acts in this area are currently before Parliament. A large number of care providers are also involved in efforts to reduce compulsion in psychiatric institutions.

Paragraph 3

b. *The Committee asks the next report to provide updated information on measures taken to reduce water and noise pollution.*

Measures taken to reduce water pollution

The EU member states adopted the Water Framework Directive (WFD) in 2000, thereby undertaking to ensure that groundwater and surface water would be of good quality by 2015 (or, under strict conditions, as soon as possible). To that end, individual management plans were drawn up for the Dutch sections of the international river basins of the Ems, Meuse, Rhine and Scheldt, reporting on the current situation and setting objectives for groundwater and surface water, describing measures taken to date and showing how quality can be maintained and, where necessary, improved. Since these plans elaborate on and substantiate policy choices in relation to implementation of the WFD in the Netherlands, they are part of the national policy on water management described in the National Water Plan. The work on formulating these plans, including the measures to reduce water pollution, was preceded by a comprehensive and thorough preparatory phase that included intensive consultation with interest groups at local, regional and national level. The four river basin management plans for the period 2009-2015 took effect on 22 December 2009.

Each plan contains basic measures, arising from European obligations and general national policy, as well as supplementary regional measures for specific water authorities with a view to achieving the WFD objectives. Substance discharges and emissions will be reduced by modifying wastewater treatment plants, cleaning up discharges in areas without sewer systems and tackling sewage overflows. Regional and site-specific measures include hydromorphological restoration, the construction of ecological corridors, and designing weirs, locks and pumping stations so that they allow fish to pass through. The additional measures also include the restoration of existing water-rich regions and projects in the areas of research, development and demonstration.

The environmental impact on surface water caused by nutrients and pollutants (such as pesticides and heavy metals) is primarily reduced by means of national measures and licensing, although supplementary regional measures also contribute. Licensing and generic measures reduce the environmental impact on groundwater due to pollutants (such as pesticides and nutrients) and groundwater abstractions. These include remediation and analysis of polluted sites, and the reduction of leaching and inflow of pesticides and other pollutants to areas where groundwater is abstracted for human consumption. The key supplementary measures in the first planning period (2009-2015) include:
• modifying 115 sewage overflows;
• removing approx. 6 million m^3 of polluted dredge (from aquatic sediments);
• improving purification of 50 wastewater treatment plants;
• establishing manure and fertilisation-free zones over and above the statutory minimum along 791 km of ditches and streams.

Investment costs for implementing supplementary measures in the four river basin management plans total more than €2.2 billion over the period 2009-2015. Half of this (€1.1bn) will be spent on measures to improve water regulation and the design of the mains and regional water systems. Over 40% of the total investment costs (€0.9bn) will be used to tackle point and diffuse sources.

Noise pollution

In the context of the Environmental Noise Directive (2002/46/EC), the Netherlands has fulfilled its obligations to undertake noise mapping and deliver the relevant information to the

European Commission. The Directive requires this to be done every five years. Work on preparing the second set of maps – with a wider scope – is almost complete, with a submission deadline of 30 July 2012. According to the European Environment Agency (see http://noise.eionet.europa.eu), the results from the first maps show that the Netherlands does not stand out in terms of noise exposure. This is consistent with the findings of the latest Eurostat SILC survey: on average, 20.3% of the EU population find noise a problem, compared with 23.6% in the Netherlands.

The significant amendments to the Noise Abatement Act, relating to motorways and mainline rail tracks, were passed in 2011 and came into force on 1 July 2012. The Act aims to ensure that noise loads cannot spiral out of control, by establishing a system of noise emission ceilings. It has also been agreed that noise loads above 65 L_{den} will be tackled.

c. The Committee asks the next report to provide updated information on any significant measures taken in the field of food safety.

In terms of public health policy, there have been no new national regulations on food safety to add to those drawn up at EU level. Food safety legislation has been harmonised across all member states.

d. Since July 2008 smoking has been banned in restaurants, bars clubs and other catering establishments. According to the report in 2006 28% of all persons over the age of 18 years of age smoked, in 2007 the percentage dropped slightly. The Committee asks to be kept informed of all trends.

See text under 11.3.

e. The Committee asks to be kept informed of all trends in alcohol consumption amongst young persons as well as any additional measures taken to reduce alcohol consumption by Young person.

See text under 11.3.

f. The report provides information on the estimated number of drug abusers and the demand for treatment. The Committee asks to be kept informed of all significant trends in drug abuse.

See text under 11.3.

g. The Committee asks the next report to provide information on measures taken to reduce injury and death by accidents as well as trends in the number of accidents.

The Netherlands has had a specific policy on injury prevention since 2008 (2008-2012), focusing on three main causes of injury and death: falls by elderly people, bicycle and scooter accidents, and suicide (http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2009/01/08/standpunt-letselpreventie.html). The RIVM report on injury prevention formed the basis of this policy (http://www.rivm.nl/Images/270102001_tcm4-54077.pdf).

Specific policies are in place on reducing road accidents (http://www.rijksoverheid.nl/documenten-en-publicaties/notas/2009/06/15/strategisch-plan-verkeersveiligheid-2008-2020.html), promoting a safer sporting environment (http://www.rijksoverheid.nl/nieuws/2011/11/18/minister-schippers-presenteert-uitwerking-actieplan-veiliger-sportklimaat.html) and health and safety at work (http://www.arbeidsveiligheid.arboportaal.nl/index.php?objectID=700 and http://www.arbeidsveiligheid.arboportaal.nl/index.php?objectID=690).

Measures taken include the development of specific activities (e.g. training children how to fall safely) and leaflets; specific campaigns (e.g. use of lights on bicycles); and changes in physical infrastructure (e.g. safer road junctions).

From 2000 to 2009 there was a positive trend in the number of injuries involving children up to the age of 4 (down 27%). A similar trend (-22%) is evident for injuries due to sport (per hour of sporting activity). However, the number of falls involving elderly people increased by 20% during the same period. Taking demographic developments into account, the increase is less marked: the risk of injury for elderly people dropped by 7%. The number of suicide attempts was stable during the period 2003-2010, but the number of recorded suicides increased by 19% (men) and 14% (women) between 2007 and 2010.

Article 12 – The right to social security

With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1. to establish or maintain a system of social security;
2. to maintain the social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;
3. to endeavour to raise progressively the system of social security to a higher level;
4. to take steps, by the conclusion of appropriate bilateral and multilateral agreements or by other means, and subject to the conditions laid down in such agreements, in order to ensure:
   a. equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;
   b. the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties.

Article 12§1

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Please refer to the Dutch report on compliance with the European Code of Social Security for the period from 1 July 2010 to 30 June 2011. In its report covering the same period, the ILO Committee confirmed that the Dutch Sickness Benefits Act (ZW) is in accordance with the Code.

Article 12§2

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information, in particular on the extent to which the branches of social security in your country fulfils (or goes beyond or falls short of) the requirements of the European Code of Social Security.

Please refer to the Dutch report on compliance with the European Code of Social Security for the period from 1 July 2010 to 30 June 2011.

Article 12§3

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information on the

improvement of the social security system as well as on any measures taken to restrict the system.

Please refer to the Dutch report on compliance with the European Code of Social Security for the period from 1 July 2010 to 30 June 2011.

Article 12§4

1) *Please describe the general legal framework, in particular the complete list of bilateral and multilateral agreements or any other means such as unilateral, legislation proposed or adopted, or administrative measures and indicate how they allow for the various social benefits the implementation of the principles provided in sub-paragraphs a) and b).*
2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.*
3) *Please provide pertinent figures or any other relevant information, Please, indicate also the length of residence requirements when applicable.*

Please refer to the Dutch report on compliance with the European Code of Social Security for the period from 1 July 2010 to 30 June 2011.

Negative conclusion of the European Committee of Social Rights

The Committee concludes that the situation in the Netherlands is not in conformity with Article 12§4 of the Charter on the ground that the legislation does not provide for the retention of supplementary benefits when persons move to a State Party not bound by Community regulations or by an agreement with the Netherlands.

The aim of the Benefit Restrictions (Foreign Residence) Act (BEU) is to be able to verify the lawfulness of the payment of benefits. When the Act came into force, the Netherlands offered all non-EU countries the opportunity to conclude a social security agreement, but not all did so.

Entitlement to old age pension for married couples is always exported even if no export treaty has been concluded, since there are no restrictions on the export of this benefit. Other social insurances are exported outside the EU only if there is an export treaty with the country in question. It must be possible to verify the lawfulness of the payment of these benefits.

The highest Dutch court dealing with matters pertaining to social security has ruled that inability to enforce is grounds for justifying not exporting benefits to a country with which no export treaty has been concluded (see ruling by the Central Appeals Court for Public Service and Social Security Matters (CRvB) on 5 August 2011, published on 11 August 2011 (national case-law database (LJN): BR4785 CRvB, 09/5289 AKW (concerning child benefit)).

The decision of the Central Appeals Court in this case can be summarised as follows. In invoking the condition set out in section 7b of the General Child Benefit Act (AKW), to the effect that child benefit is allocated to a child living abroad only if that child lives in a country with which an export treaty has been concluded, the State has not unlawfully discriminated on the basis of place of residence, as assessed in the light of article 14 of the European Convention of Human Rights (ECHR) in conjunction with article 1 of Protocol No 1 to that same Convention. Policy regarding the export of benefits to a country with which a treaty has yet to be concluded has been consistently applied. Given the ample margin of appreciation, it cannot be argued that the Dutch State was and is obliged to promote the conclusion of a treaty with a number of countries, or to act as if one were in place. In the light of the aim of the Benefit Restrictions (Foreign Residence) Act, the fact that only a relatively small number of actual or potential benefit claimants are affected by this legislation is not of crucial importance. There is no question of any unjustified, unequal treatment in the decision not to award child benefit by reason of the provisions of section 7b of the General Child Benefit Act; reliance on articles 3 and 27, paragraph 4, of the International Convention on the Rights of the Child is of no avail to the appellant either.

Dutch policy is not to export supplementary benefits or incapacity benefit for young disabled people either within or outside the EU. The amount of these benefits is indexed to the Dutch minimum benefit level and they are paid out of the public purse rather than via social security contributions. For people in receipt of supplementary benefits under the Social Security Supplements Act (TW), other income is also taken into account. These benefits have elements of both social assistance and social insurance. In itself, the Social Security Supplements Act does not cover social security risks, but simply supplements employee insurance contributions (incapacity, sickness and unemployment benefits) up to the Dutch minimum benefit level.

1. These benefits have elements of both social assistance and social insurance.

2. They therefore fall under the special non-contributory cash benefits that do not need to be exported within the EU on the basis of Annex X to art. 70 of Regulation 883/2004.
3. In adopting this interpretation of the non-exportability of supplementary benefits under the Social Security Supplements Act, the Netherlands continues to comply with article 12.4 of the Charter concerning equal treatment with its own nationals of the nationals of other Parties.

A final point to be noted here is that the ILO Committee made no comments on the Social Security Supplements Act with regard to the European Code of Social Security.

Questions from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

Paragraph 1

a. *The Committee asks the next report to provide detailed information on the functioning of the appeal system that is in place to solve any disputes relating to decisions of employers or insurance companies on the granting and payment of sick pay, the number of complaints per year, the substance of relevant case law and any follow-up measures. Meanwhile the Committee reserves its position on this point.*

Under the Dutch Civil Code, employers are required to continue paying sick employees 70% of their wages for a period of 104 weeks. It is of course conceivable that an employer and employee may hold different views on whether the employee is too ill to work, in which case the employee can ask the Employee Insurance Agency (UWV) for a second opinion from an expert. The collective labour agreement (if one exists) may stipulate that the expert be appointed by a body other than the UWV, for example the safety, health and welfare service. The second opinion is simply a recommendation, but it is likely that the employer and employee will accept it, thus avoiding the need for legal proceedings, as confirmed by research. The number of actions to recover wages in connection with incapacity for work is small.

If the employer disputes the opinion of the expert that the employee is too ill to work, the employee may lodge an appeal and is required to submit the second opinion, failing which the court will deny an application for continued payment of sick pay.

The number of second opinions delivered regarding whether employees are able to work is a good indicator of the method of assessing whether someone is genuinely ill or not.

In 2011 the UWV issued 4,863 second opinions on whether an employee was too ill to work, a figure that has remained fairly steady since 2008. The same pattern is evident for sickness absence, which has been just over 4% for years. There is no relevant case law that would require follow-up measures.

In its report covering the period from 1 July 2010 to 30 June 2011, the ILO Committee confirmed that the Dutch Sickness Benefits Act is in accordance with the European Code of Social Security.

b. *To assess whether a significant proportion of the total and/or active population in the Netherlands is guaranteed an effective right to social security with respect to the benefits provided under each branch, the Committee asked for figures in percentage indicating the personal coverage of each branch of social security.*

Please refer to the European Code of Social Security report for the period from 1 July 2010 to 30 June 2011.

c. *On the basis of the above and pending receipt of clarifications concerning the protection of self employed persons against the financial consequences of being incapacitated for work, the Committee observes that the personal coverage of the social security system is satisfactory and requests that the next report continue to provide the relevant up-to-date figures.*

Since the repeal of the Incapacity Insurance (Self-employed Persons) Act (WAZ) in 2004, self-employed individuals have no longer been required to have compulsory public insurance against the risk of occupational disability, and can now decide for themselves whether and how they wish to cover themselves against this risk. Several options are available if they choose to insure themselves.1. Self-employed people can make use of the standard insurance policies offered by private insurance companies.
2. If they have difficulty obtaining standard insurance cover, they can take advantage of insurance companies' 'safety net' insurance.
3. New self-employed individuals who were previously required to have employee insurance can voluntarily continue to be insured against occupational disability.

According to research, just under half of all self-employed people are insured.

d. The Committee asks for detailed explanation of the various grounds of considering somebody as "culpably unemployed", detailed information on which grounds have caused the highest number of disputes, and what followup measures have been taken on appeals.

Please refer to the European Code of Social Security reports for the years 2005-2006, 2006-2007, 2007-2008 and 2008-2009. In line with the ILO Committee's request, the Dutch Ministry of Social Affairs and Employment wrote to the Employee Insurance Agency (UWV) drawing attention to the Netherlands' obligation under Article 68(f) of the Code to apply sanctions only where neglect or recklessness amounted to wilful misconduct, directly causing the unemployment of the person concerned. The ILO Committee has expressed its satisfaction with this response [CS-SS (2011)11^{E} REV].

Paragraph 2

e. The Committee notes from Resolution CM/ResCSS(2008)12 of the Committee of Ministers on the application of the European Code of Social Security and its Protocol by Netherlands (period from 1 July 2006 to 30 June 2007) that the law and practice in the Netherlands gives full effect to all the parts of the Code and the Protocol, with the exception of Part VI which the government intends to denounce, subject to further information on the application of several parts of the Code (regarding medical care, unemployment benefit, old age benefit, invalidity benefit, survivors' benefit and standards to be complied with by periodical payments).

The Netherlands denounced Part VI of the Code by submitting an official declaration by the Minister of Foreign Affairs to the Secretary General of the Council of Europe on 22 February 2007. As a result, the Netherlands is no longer bound by Part VI of the Code, with effect from 17 March 2008. The denunciation was approved by the Dutch Parliament (House of Representatives and Senate) on 29 September 2009 (see Bulletin of Acts and Decrees 474 of 20 November 2009).

For the record, it should be mentioned that the Netherlands ratified all parts of the Revised Code on 22 December 2009, and is currently the only country to have done so. The Revised Code will enter into force when at least one other country ratifies it.

Paragraph 3

f. The Committee has taken due note of the description of the content of such regulations and asks the next report to provide information on the extent of the changes they introduced

(categories and numbers of people concerned, levels of allowances before and after alteration).

The aim of the Work and Income (Capacity for Work) Act (WIA) is to encourage partially incapacitated people to seek employment and to provide income protection in the event of occupational disability. The effects of this Act should be considered in the context of the full raft of policy measures on incapacity for work, including the Eligibility for Permanent Incapacity Benefit (Restrictions) Act, the extension of the compulsory sick pay period to two years and the revised Assessment Decree (and the re-assessment performed under this legislation).

All the measures introduced in the past ten years have resulted in an activating occupational disability system. With regard to the number of new incapacity benefit claimants under either the old Invalidity Insurance Act (WAO) or the new Work and Income (Capacity for Work) Act (WIA), there has been a marked change in the trend, with the likelihood of people claiming this benefit decreasing by 71% during the period 1999-2009.

The categories of persons covered under the WIA and the WAO are identical.

The following changes were introduced under the WIA. Firstly, unlike the WAO, the WIA now makes a distinction between people who are still able to work and those who are permanently totally incapacitated, with the emphasis on encouraging the former to return to work and providing income protection for the latter. Incapacity benefit for the second group amounts to 75% of the full daily wage until the age of 65, which is more than was paid out under the old WAO (70% of the daily wage and then 70% of the follow-up daily wage (which was lower).

The evaluation of the WIA shows that the number of new claimants under the Income Support Scheme for individuals registered as fully and permanently incapacitated (IVA) is small and mainly comprises employees with serious ailments. However, this number will rise in the future as a result of benefit claimants under the Work Resumption (Persons Partially Capable of Work) Scheme (WGA) transferring to the IVA scheme.

Secondly, financial incentives have been introduced to encourage people still able to work to do so. Initially they receive wage-related benefit, which includes unemployment benefit, amounting to 70% of the daily wage if they are unemployed. If they start work, their total income always rises because only part of their earned income is taken into account in calculating benefit entitlement. Thereafter they are entitled to either follow-up benefit (if unemployed), related to the degree of incapacity and the statutory minimum wage, or a wage supplement (if in work), related to the degree of incapacity and the daily wage. The amount of wage supplement is therefore at least equal to the follow-up benefit, but is usually higher. In any event, total income is always higher the more a person earns; in other words, working – or working longer hours – is always worthwhile.

The WIA evaluation indicates that most claimants of incapacity benefit under the WGA are receiving wage-related benefit, 90% of whom are thereafter entitled to a wage supplement, either because they are fully but not permanently incapacitated or because they are sufficiently exploiting their remaining earning capacity. A large proportion of benefit claimants under the WGA scheme are automatically entitled to a wage supplement because they fall into the first category. In practice, as at the end of 2009, most benefit claimants

received wage-related benefit (59%) and subsequently a wage supplement (37%). Currently, only a small group (4%) go on to claim follow-up benefit.

The wage-related benefit paid out under the WGA scheme is equal to the combined unemployment/WAO incapacity benefit previously received by people who are partially incapacitated. The payment of wage supplements is an improvement on the WAO because the amount is related to the daily wage rather than the follow-up daily wage (which is lower). Generally speaking, the WGA follow-up benefit is lower than the old WAO follow-up benefit. Accurate information about the impact on income as a result of the changeover from the WAO to the WIA is not available. Most benefit claimants receive benefit (IVA benefit, WGA wage-related benefit or WGA wage supplement) amounting to at least the old WAO benefit or more.

g. As regards the Invalidity Insurance (Young Disabled Persons) Act (WAJONG), the Committee has noted that the Government is worried by the growth of beneficiaries of this incapacity benefit (which has risen by about 10,000 on an annual basis) and that it is working on measures in order to reduce this growth. The Committee asks the next report to provide up-dated information in this regard.

The amended Work and Employment Support (Young Disabled Persons) Act (*Wet werk en arbeidsondersteuning jonggehandicapten*, WAJONG) came into force on 1 January 2010, replacing the Invalidity Insurance (Young Disabled Persons) Act (which had the same acronym in Dutch). Under the old legislation, the emphasis was mainly on what young people were unable to do, which explains why they were eligible for care provision, additional financial support in education and training and, from the age of 18, lifelong incapacity benefit. The Dutch government has now taken the opposite approach, focusing primarily on what young people *can* do. This principle now underlies current government policy. The new Act is designed to improve young disabled people's chances of finding paid employment to enable them to play an active part in society. The most important aim is therefore to empower these young people by helping them to find and keep a regular job and thereby contribute to integrating them into society more effectively. All young people should be treated equally and should have the same opportunities. A distinction will only be made if and to the extent that this is necessary in order to help someone find and retain suitable employment. The main focus of the new legislation is therefore on employment support rather than entitlement to benefit, while it continues to provide an income safety net for those with no prospects of finding employment. In the case of young people deemed incapable of ever working, i.e. those who are fully and permanently incapacitated, priority is given to offering them income protection.

The Act covers those who apply for benefit on or after 1 January 2010. One key aspect of the new legislation is entitlement to employment support, with young disabled people who are able to work receiving as much help as possible in finding and staying in a job. An individually tailored 'participation plan', based on previous education and/or training, is drawn up together with the young person concerned (and possibly his or her parents), setting out, for instance, the best way to find a job, the support available and the young person's rights and obligations. Assistance may take the form of adaptation of the workplace, advice and mediation when looking for work, personal support provided by a 'job coach', transport arrangements, help in setting up in business, a specific job offer, a reintegration programme, training or study and/or income support.

Young disabled people can apply for income support to supplement their earnings from employment. The general approach is to make going to work an attractive and worthwhile prospect to encourage them to generate as much of their income as possible themselves. To ensure that these young people have the chance to develop, like their peers, the first step in the application process is to make a provisional assessment of their employment options. At the age of 27 or – if the disabled person concerned is older than 20 when he or she registers with the Employee Insurance Agency (UWV) – after a period of seven years, a final assessment is carried out in which the main focus is on continuation of employment. If the initial assessment indicates that the young person is completely and permanently unable to work, the priority then is to offer income protection in the form of benefit.

Young disabled people who are still studying or training and who are entitled to employment support may, on request, receive appropriate income support in addition to their student grant, or assistance with training fees. The provision of this income support acknowledges the fact that young disabled people are unable, or less able, to earn extra income while they are studying.

Initial evaluations suggest that the new legislation has led to a decline in the number of young disabled people awarded incapacity benefit, from 17,800 in 2010 to 16,300 in 2011 – the first reported year-on-year decrease since 2001. This downward trend is expected to continue.

h. To assess the impact in particular of the new requirements to be met to determine the amount of the unemployment benefit on the adequacy of the benefit, the Committee asks the next report to provide the relevant information under Article 12§1 (i.e. indication of the minimum amount of the benefits).

Please refer to the European Code of Social Security report for the period from 1 July 2010 to 30 June 2011.

i. To ascertain the effects of the developments in the health care, invalidity and unemployment branches of the social security system on the right to access and maintain benefits and pensions, the Committee asks that the next report contain information on the results obtained by the changes introduced, including statistical data.

Please refer to the European Code of Social Security report for the period from 1 July 2010 to 30 June 2011.

Paragraph 3

j. It asks if and how the Netherlands guarantees equal treatment with regard to social security rights for nationals of the other States Parties, namely Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Moldova and Ukraine.

Everyone who is legally employed in the Netherlands, regardless of nationality, pays employee insurance contributions to cover unemployment, illness and incapacity. Nationals of Albania, Andorra, Armenia, Azerbaijan, Bosnia-Herzegovina, Georgia, Moldova and Ukraine who enjoy legal employment status in the Netherlands, who become unemployed, ill or incapacitated for work and who fulfil the requirements of the relevant legislation are entitled to unemployment, sickness or incapacity benefit like any Dutch citizen.

Everyone who is legally resident in the Netherlands, regardless of nationality, pays national insurance contributions to make provision for old age pension, surviving dependant's pension and child benefit. Nationals of Albania, Andorra, Armenia, Azerbaijan, Bosnia-Herzegovina, Georgia, Moldova and Ukraine who enjoy legal residence status in the Netherlands and who fulfil the requirements of the relevant legislation are entitled to these benefits like any Dutch citizen.

k. The Committee asked for information on any measures planned to redress this situation. In the absence of any such information in the report, the Committee repeats its question.

Please refer to the European Code of Social Security reports for the years 2008-2009 and 2010-2011. In its report covering the period from 1 July 2010 to 30 June 2011, the ILO Committee confirmed that the Dutch General Old Age Pensions Act (AOW) is in accordance with Part V of the Code.

l. The Committee asks for the next report to state what measures, unilateral or otherwise, the Government has taken with regard to countries not covered by the current agreements to guarantee that accrued benefits are retained.

Please refer to our response to your negative conclusion in this article.

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

Article 13§1

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

Work and Social Assistance Act (WWB)
On 1 October 2009 a separate social assistance act was introduced for young people aged 26 and under: the Investment in Young People Act (WIJ). Accordingly, the WWB no longer applied to this group. The WIJ was intended to encourage young people's sustained participation in the labour market, and to prevent their relying on social assistance benefit. Under the WIJ, young people had the right to a placement comprising work and/or learning offered by the municipality. Income support was only granted if the individual concerned accepted the placement offered and performed it satisfactorily, and only if their income or capital was below benefit level.

For young people, the introduction of the WIJ shifted the emphasis to working or learning, or a combination of the two, with income support closely linked to that. The government endorsed the basic principle of the WIJ, but believed that the system allowed too much scope for young people to sit back and wait for things to happen. The WIJ was, therefore, abolished on 1 January 2012. Young people now once again fall under the WWB. The rules have been tightened up, and young people are now expected to find work themselves. Before they can apply for social assistance benefit, young people need to register with the Employee Insurance

Agency and then spend up to four weeks searching for employment or training**.** If at the end of this period they have not found work or training, despite having made a reasonable effort to do so, social assistance benefit will be paid out retrospectively for those four weeks – on the condition that the person concerned is entitled to it.

Table 13.1: Standard social assistance benefit as of 1 January 2011

Standard social assistance benefit	AMOUNT
Single people	€656.93* net per month, including holiday allowance
Single parents	€919.70* net per month, including holiday allowance
Married/cohabiting couples	€1313.85 net per month, including holiday allowance

* Single people and single parents are eligible for a maximum allowance of €262.77 net per month (20% of the net minimum wage) on top of this if they cannot share living costs, e.g. accommodation costs, with anyone else.

Table 13.2: Number of social assistance payments

	AT YEAR-END 2009	AT YEAR-END 2010	AT YEAR-END 2011
Number of social assistance claimants	316,570	345,240	356,280

Source: Statistics Netherlands (CBS)

Article 13§2

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

There have been no new developments.

Article 13§3

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

There have been no new developments.

Article 13§4

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Aliens who do not hold a residence permit are unable to take out health insurance. In principle, this means they are responsible for covering the cost of medical care themselves. However, if aliens are unable to meet these costs, the healthcare provider may, under certain conditions, recover them from the Healthcare Insurance Board.

These conditions are as follows:
- the alien is an illegal resident;
- the alien has submitted an application for a residence permit;
- the alien has lodged an objection to a negative decision regarding an application for a residence permit.

This regulation does not apply to:
- Dutch citizens (including those from Bonaire, St Eustatius and Saba);
- citizens of Aruba, Curaçao and St Maarten;
- EU citizens;
- citizens of Iceland, Norway, Liechtenstein and Switzerland.

There have been no other new developments.

Negative conclusion of the European Committee of Social Rights (ECSR)

The Committee concludes that the situation in the Netherlands is not in conformity with Article 13§4 of the Revised Charter as it has not been established that all unlawfully present persons in need receive emergency social assistance.

Accommodation for aliens who are legally resident in the Netherlands as asylum seekers is the responsibility of the Central Agency for the Reception of Asylum Seekers (COA). They receive cash benefits under the Asylum Seekers and Other Categories of Aliens (Benefits) Order (RVA).

Aliens who have a residence permit and are therefore legally resident in the Netherlands, and aliens who are legally resident in the Netherlands because they are appealing the loss of their right to residence, can apply for cash benefits under the Work and Social Assistance Act (WWB).

Aliens who have fallen victim to human trafficking while illegally resident and who are exercising their right to reflect on whether to file a criminal complaint with the police are legally resident in the Netherlands as their departure will have been deferred. During their period of reflection they are eligible for cash benefits under the Certain Categories of Aliens (Benefits) Order (RVB). If they do file a criminal complaint or cooperate with the police in some other way, they will be granted a residence permit and be eligible to claim under the WWB.

Aliens who have fallen victim to domestic violence, honour-based violence or human trafficking while illegally resident (who are not exercising their right to reflect on whether to file a criminal complaint) are eligible for cash benefits under the RVB if they are staying in a women's refuge and have applied for a residence permit on humanitarian grounds. This applies while the Immigration and Naturalisation Service (IND) is assessing their application. Once a residence permit has been granted, they will be eligible to claim under the WWB.

Illegal aliens who are being detained with a view to deportation fall under the Custodial Institutions Agency and are entitled to the provisions for detainees.

Illegal aliens who do not fall under any of these categories receive no financial support. The reason for this is that the Netherlands wants to avoid actively enabling aliens to continue unlawful residence by allowing them to obtain assistance and cash benefits without their residence status being assessed. This also prevents illegal aliens and those who have not been or have not yet been admitted to the Netherlands from giving the impression that they are living here lawfully.

Under the Benefit Entitlement (Residence Status) Act, illegal aliens are entitled to urgent medical assistance. (They are not excluded from medical care, only from access to healthcare insurance. They can access any medical care if they can pay for it, but only emergency care will be reimbursed.) Illegal aliens are also entitled to legal aid, and, if they are children, to education.

Question from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

paragraph 1
The Committee asks what forms of social assistance may be refused in such circumstances, whether the assistance is withdrawn in its entirety, including the supplements and whether the withdrawal of such assistance may amount to the deprivation of means of subsistence for the person concerned.

In principle, persons entitled to social assistance benefit as a safety net provided by Dutch social security have an obligation to obtain and accept any reasonable offer of work as far as they are able. This must, of course, take into account whether the work matches the individual's capabilities, in terms of health and strength. If paid employment is not yet an option, the person concerned must make use of the services provided by the municipality aimed at helping them find employment or return to work (obligation to reintegrate). The municipality should draw up an ordinance to this effect. If the municipality notes that the person in question is not meeting the obligations specified in the Work and Social Assistance Act (WWB), or is otherwise taking insufficient responsibility, the municipality is obliged to reduce the social assistance benefit. This reduction affects part of the benefit and lasts for a maximum period of three months. However – depending on individual circumstances – it can be as high as 100% of the benefit. Benefit will not be reduced if there is no form of culpability. Once the reduction period has elapsed, the municipality must reassess the decision.

Article 14 – The right to benefit from social welfare services

With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:

1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;
2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

Article 14§1

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

There have been no new developments with regard to the general legal framework.

In its evaluation of the Social Support Act (WMO) for the period 2007-2009, the Netherlands Institute for Social Research (SCP) reported that 'The Social Support Act is working, in the sense that most local authorities are implementing the Act as the legislator intended and with the instruments provided by the Act'. People are well satisfied with the support available and local authorities are now seeking to link up with other relevant policy domains. Clients rate the household help they receive highly, awarding an average score of 8.4. The development of the Act is an ongoing process and local authorities and their partners are vigorously pursuing their efforts in this area.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The Ministry of Health, Welfare and Sport defines the framework within which local authorities can decide on their own policy, based on the composition and demands of their residents. Devolving responsibility for social support to local government enables services to be individually tailored, making optimum use of local services. This requires a new mindset, with the emphasis no longer on individuals' limitations, but on their potential to participate in society with a little support. What can they do by themselves, what support can they organise themselves and in what areas do they need help from the local authority? There is no standard list of public services to which people are entitled because of their limitations/disabilities; instead a model is used to provide tailored support based on individual needs. Clients (and their own support network) work closely with the local authority to determine what is required and how to achieve it. Informal care and voluntary organisations have a part to play in this. Both the Association of Netherlands Municipalities (VNG) and pressure groups are involved in bringing about this change of mindset.

Local authorities can make use of a website with information about how social support can be organised, including practical examples and also tips and advice on implementation locally. The relationship between housing, welfare and health care is also a key factor at local level. Local authorities are responsible for these policy areas and are therefore in a position to deliver tailored services in all three.

3) Please provide pertinent figures, statistics or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

Funding under the Social Support Act is currently running at about €5 billion, covering household help (approx. €1.1bn) and the budgets previously allocated for the old Services for the Disabled Act (approx. €1bn) and Welfare Act (approx. €2.5bn). Some €400 million is reserved specifically for shelters in the community.

In 2008 around 450,000 people received household help, and more than 300,000 services were provided: these related to home adaptations (approx. 120,000), individual and collective transport (80,000 each) and wheelchairs (60,000). In the same year some 70,000 people made use of shelters in the community, specifically 24-hour accommodation, supervised housing and also overnight accommodation in a night shelter or use of a day centre.

Article 14§2

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
3) Please provide pertinent figures, statistics or any other relevant information to demonstrate the participation of the voluntary sector to the provision of social services, as well as the effective access of individuals to these services.

During the period from January 2008 to December 2011, the Exceptional Medical Expenses Act (AWBZ) was not amended.

Questions from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

paragraph 1:

a. *In reply to the Committee, the report states that annual spending on youth services rose from € 766 million in 2004 to € 1.05 billion in 2007. The Committee asks how much is spent annually on all social services.*

Annual expenditure on social services covers both the Social Support Act (WMO) and the Exceptional Medical Expenses Act (AWBZ). Expenditure on the WMO is specified in article 14, para. 1.3. The table below gives an overview of AWBZ expenditure.

2008	2009	2010	2011
€21.1 billion	€22.9 billion	€24 billion	€24.6 billion

Reference to article 43.2.2:

2008: http://www.rijksbegroting.nl/2010/voorbereiding/begroting,kst132834b_6.html
2009: http://www.rijksbegroting.nl/2011/voorbereiding/begroting,kst148633_8.html
2010 and 2011: http://www.rijksbegroting.nl/2012/voorbereiding/begroting,kst160371_9.html

The *Health Insurance in the Netherlands* brochure (Dutch only) can be viewed here: http://www.rijksoverheid.nl/documenten-en-publicaties/brochures/2011/04/21/ziektekosteverzekering-in-nederland.html

b. *The Committee asks again what conditions service providers must meet to be able to offer their services.*

Service providers must obtain formal accreditation from the Minister of Health (in accordance with the Healthcare Institutions (Accreditation) Act*) to be able to offer services insured through the Exceptional Medical Expenses Act** and the Healthcare Insurance Act***, and must meet standards set by the Care Institutions (Quality) Act****. All service providers offering services financed under the Social Support Act are required to meet standards set by local authorities.

*
http://www.rijksoverheid.nl/onderwerpen/wet-toelating-zorginstellingen/kapitaallastenbrief

**
http://www.rijksoverheid.nl/onderwerpen/algemene-wet-bijzondere-ziektekosten-awbz/vraag-en-antwoord/wat-is-de-algemene-wet-bijzondere-ziektekosten-awbz-en-wie-is-daarvoor-verzekerd.html

***
http://www.rijksoverheid.nl/onderwerpen/zorgverzekering

****
http://www.rijksoverheid.nl/onderwerpen/kwaliteit-van-de-zorg/kwaliteitseisen-zorginstellingen?ns_campaign=Thema-Gezondheid_en_zorg&ro_adgrp=Kwaliteit_van_de_zorg&ns_mchannel=sea&ns_source=google&ns_linkname=kwaliteitswet%20zorginstellingen&ns_fee=0.00

Article 23 – The right of elderly persons to social protection

With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

- to enable elderly persons to remain full members of society for as long as possible, by means of:
  a. adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
  b. provision of information about services and facilities available for elderly persons and their opportunities to make use of them;
- to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:
  a. provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
  b. the health care and the services necessitated by their state;
- to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Housing
Under the Subsidised Rental Sector (Management) Decree (BBSH), housing associations are required to provide suitable housing for vulnerable groups, including the elderly. Older people who cannot afford to pay the full amount of rent themselves can claim housing benefit under the Housing Benefit Act. There have been no changes to this system in recent years.

Support
Local support is provided under the Social Support Act (WMO), which is discussed in article 14.

Health care
Health care for the elderly is mainly funded through the Exceptional Medical Expenses Act (AWBZ) (see previous report) and covers care in residential and nursing homes and at home. Some parts of this Act have now been incorporated in the Social Support Act, but there have been no major changes in the past few years.

Curative care services are provided through private insurance, based on the provisions of the Healthcare Insurance Act (ZVW) (see previous report). A few minor changes have been made to both the standard and the supplementary health insurance packages in the past few years.

Partly in view of the financial situation of the Dutch government, reforms and cost-cutting measures in health care would seem to be inevitable. With this in mind, the Rutte government has produced various legislative proposals and plans during the past 18 months. At the time of writing, however, these were on hold (caretaker period).

Pensions
The General Old Age Pensions Act (AOW) provides a basic pension for people aged 65 and over. To ensure that pensions are still affordable in the future, the Rutte government has been working on legislation to radically revise the pension system, including a bill to raise the retirement age stepwise to 67, while keeping pension contributions at the same level. These measures should make pensions more sustainable in the face of population ageing and better able to withstand fluctuations in the financial market. During the caretaker period when this report was written, a new bill was drafted to speed up the introduction of the higher retirement age, but this has not progressed either.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Housing
During the reporting period, the action plan on housing for the elderly (2007-2011) came to an end. The aim of this plan was to make local authorities, housing associations and other relevant organisations more aware of the need to make more suitable housing available for the elderly and to develop plans at local level to achieve this.

Other areas
With regard to social support, health care and pensions, there are no measures to report aimed at implementing the statutory framework. Programmes are, however, in place, for instance in the **healthcare sector**, to improve the quality of health care for older people, such as the National Programme on care for the elderly and the Dementia Delta Plan. Since 2007 efforts have been made to reduce the number of shared rooms in facilities for the elderly to give individual clients more privacy. This process was speeded up in 2009-2010, with funding of €160 million as an incentive.

3) Please provide pertinent figures, statistics or any other relevant information on measures taken to ensure that elderly persons have access to adequate benefits in cash or in kind; on the level of public expenditure for social protection and services for the elderly; on the accessibility of measures and the number of elderly people benefiting from them; on the number of places available in institutions for elderly persons; on the number of elderly living in such institutions, and on whether a shortage of places is reported.

Housing
In July 2011 the results of the 'Investing in the future (2009)' monitor were sent to the House of Representatives, showing that the shortage of suitable housing for the elderly had decreased by 45,000 to 87,000 since 2006. The stock of suitable housing for this group had also increased to 1.8 million, out of a total stock of around 7 million.

Health care
The table below gives a few key figures on funding of care for the elderly under the Exceptional Medical Expenses Act (2010):

Client group	**Inpatient care**	**Home care**
Elderly people with psychogeriatric disorders	55,000	17,000
Elderly people with somatic disorders	109,000	210,000
Total	**164,000**	**227,000**

Inpatient care	
Residential homes for the elderly	approx. 1,300
Somatic nursing homes for elderly people with somatic disorders	approx. 300
Psychogeriatric nursing homes	approx. 400
Total	approx**. 2,000**

Questions from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

a. The Committee therefore asks if non-discrimination legislation to protect elderly persons outside the field of employment exists, or whether the authorities plan to legislate in this area.

Non-discrimination, i.e. equal treatment, of all people residing in the Netherlands is guaranteed under article 1 of the Dutch Constitution. The age criterion is specifically dealt with only in the Equal Treatment in Employment (Age Discrimination) Act (WGBL), which entered into force on 1 May 2004 and prohibits discrimination in employment and training on the grounds of age. There is no specific legislation that addresses discrimination in a general sense against elderly people.

b. The Committee notes from the EU Peer Review on Freedom of choice and dignity for the elderly43 that the systems of social support, long-term care, housing and acute care are undergoing reforms……..The Committee asks to be kept informed on these ongoing reforms.

Successive Dutch governments have developed policies to future-proof the quality and financial viability of care and support systems. There is a trend towards devolving responsibility in these areas to local government to enable more integrated, tailored services to be provided. At the same time, policy also aims to curb the increase in the cost of both curative and long-term care. In the case of the latter, the present caretaker government has invested an additional €800+ million, mainly to create more jobs for long-term care nurses.

During the reporting period there were no changes in this system as regards housing for the elderly.

c. The Committee asks for information on the legal framework related to assisted decision making for the elderly, and, in particular, whether there are safeguards to prevent the arbitrary deprivation of autonomous decision making by elderly persons.

In the Netherlands, a person's legal competence can only be restricted by a court order appointing a tutor, guardian or administrator to represent the person concerned.

In the area of long-term care, a care and compulsion bill is currently before Parliament which states explicitly that clients themselves will decide on the care they receive. A representative of a client will only have a role to play if an expert, in accordance with the applicable guidelines, has determined that the client is not competent to make certain decisions. Clients who refuse care, even though they no longer have the ability to make their own healthcare decisions or express a choice, will not be treated unless this would have a serious adverse effect on them. To help clients make decisions, care providers will be required to employ a client confidential adviser, who will listen and give independent advice in confidence.

d. With a view to assessing the adequacy of income guarantees for elderly persons who receive a small or no earnings-related old-age pension, the Committee asks what the net amount of the AOW pension is, namely to clarify whether low-income elderly persons are entitled to the full flat-rate old-age pension of € 964.91 per month.

All persons lawfully resident in the Netherlands – regardless of their nationality – who have not yet reached the age of 65, and all non-residents who work in the Netherlands and accordingly pay Dutch income tax, are insured under the General Old Age Pensions Act (AOW). Individual circumstances dictate whether someone is deemed to live in the Netherlands. Everyone who has always been insured between the ages of 15 and 65 will receive a full old age pension. A 2% reduction applies for each year in which no insurance was paid (e.g. due to a period of residence abroad).

The full old age pension for a single person is €1,003.26 net per month in 2012 (excluding holiday allowance). State pensions are not means-tested for recipients aged 65 and over. Elderly people who do not receive a full old age pension are entitled to supplementary social assistance benefit under the Work and Social Assistance Act (WWB) if their total income (comprising old age pension, any supplementary pension, other income and assets) is below the guaranteed minimum benefit income.

e. The Committee wishes to know what the Government is doing to evaluate the extent of the problem, to raise awareness on the need to eradicate elder abuse and neglect, and if any legislative or other measures have been taken or are envisaged in this area.

On 30 March 2011 the State Secretary for Health, Welfare and Sport submitted the action plan 'The elderly in safe hands' *(Ouderen in veilige handen)* to the House of Representatives, presenting ten measures to tackle abuse of the elderly. These relate to prevention, early detection, reporting and improved victim support. A vigorous approach towards perpetrators is also being pursued. The action plan will run from 2011 until the end of 2014 and a budget of €10 million per year has currently been set aside for its implementation.

Elder abuse is defined in the action plan as any act (or the failure to act appropriately) vis-à-vis someone aged 65 or over who is in a situation of partial or complete dependence, by those who have a personal or professional relationship with the person in question, which results in physical, psychological and/or material damage to that person. This excludes abuse of the elderly by strangers – for instance on the street – and also care mistakes (including medical errors). Other remedies exist in these cases.

During the first phase of implementing the action plan, the emphasis has been on measures that help break the taboo about elder abuse and improve early detection. Below are some of the results achieved so far.

- The Healthcare Inspectorate (IGZ) launched a hotline for elder abuse in care in June 2011.
- A bill on a compulsory protocol for reporting domestic violence and child abuse has been submitted to the House of Representatives, detailing the steps to be taken by professionals who suspect cases of domestic violence (including elder abuse).
- In June 2012 the 'volunteers against elder abuse' tool kit will be presented to organisations that work with volunteers and will provide general information, guidelines for management and practical tips for the volunteers themselves.
- The public information campaign 'The elderly in safe hands' will be launched in mid-2012 with the aim of encouraging older people and their friends or relatives to talk about elder abuse.
- To improve the expertise of professionals in relation to elder abuse, an e-learning module is being developed and will be available for use in training from September 2012.
- The action plan also focuses attention on local authorities, with the aim of ensuring a more integrated approach to elder abuse at local level (ranging from preventing and stopping

abuse to providing help and support for victims) and incorporating this approach into local government policy on domestic violence and informal care.
- The 'financial exploitation' project will be developed in the first half of 2012 in consultation with housing associations, banks and local authorities.
- In 2012 a plan will also be formulated to ensure that excessive stress and strain among informal carers (possibly resulting in elder abuse) is detected as early as possible and prevented.

f. Under the 2007 Social Support Act (Wmo), municipalities are responsible for providing social support. The introduction of the Wmo is seen by the authorities as an opportunity to improve the service provision to citizens and clients. The Committee asks to be kept informed on the practical implementation of this new Act, namely as to what services and facilities are made available for elderly persons under its remit (day care centres, home help services, meals, home nursing, rebates on public transport, etc.).

The essence of the Social Support Act (WMO) is that local authorities are required to take measures to ensure that people can continue to lead independent lives as long as possible and can participate in all facets of society, whether or not with help from friends, family or acquaintances, in a spirit of solidarity. If this is not possible, support is available from the local authority, for instance for volunteers and informal carers. The Act can also provide social services such as household help and ensures that people know what help and information is available to them. Depending on the nature of the obstacles people encounter, various services tailored to their domestic circumstances are offered. With regard to meals, possible options include making use of a caterer, where people can order hot meals at their own expense and have them home-delivered, eating in a local home for the elderly, or taking advantage of the community meals-on-wheels scheme. Depending on the individual's financial position, a personal contribution may be required.

The same principle applies for home care, home adaptations and transport (within the municipality and the immediate vicinity). In the area of transport, the aim is to work towards accessible public transport and an alternative transport system (cross-regional transport comes under central government). Local authorities have a range of options, including issuing disabled parking badges and creating disabled parking places close to home, making public transport more accessible, reimbursing taxi or shared-taxi fares, providing a mobility scooter, etc. The final choice is made based on the resources and needs of the individual and of the local authority.

g. It also asks if dependent elderly persons are entitled to an allowance to face the cost of caregivers.

Under the Social Support Act, care is provided in kind and free of charge, except for a personal contribution in some cases. Local authorities can also offer a personal budget, allowing the recipients to purchase the support they need as and how they see fit.

h. The Committee also asks how the quantity and quality of services for the elderly provided by the different municipalities will be monitored, whether there is a charge for these services and if there are channels for elderly persons to complain about the services.

With the advent of the Social Support Act, the quantity of services provided by local authorities is no longer relevant. The goal is for people to be able to participate in society, and local authorities deliver tailored services with this in mind. Priority is given to making use of

general services, but if these are inadequate, the emphasis switches to services geared towards people with similar support needs and, if necessary, individual services. As a result, it is no longer possible to gauge how many people are making use of general services, since no statistics are kept on whether users are availing themselves of a particular service because of their inability to participate in society or because of their ordinary needs. For example, people who risk becoming isolated can be given the opportunity to attend a community centre and/or join a club. No record is kept of their underlying reasons for doing so, however.

Quality is assessed based on the type of service provided. In the case of general services, this is the responsibility of the Food and Consumer Product Safety Authority (VWA) or the Building and Housing Inspectorate, for example. When it comes to care, the Care Institutions (Quality) Act is applicable, or the Healthcare Inspectorate can intervene.

If an individual does not agree with a decision of his/her local authority, he/she can lodge an objection with the municipal executive and subsequently an application for review to the administrative or civil courts, and can complain to one of the inspectorates or a professional disciplinary board.

i. The Social Support Act (Wmo) requires municipalities to take measures to enable persons that require assistance to run a household and to be mobile in and around the dwelling. The Committee finds that this type of measure can contribute to the objective of maintaining people in their own homes for as long as possible, in line with the Charter requirements. It asks in this respect whether there are public policies providing financial assistance for the adaptation/renovation of housing of elderly persons, and in the affirmative, how many elderly persons actually benefit from this type of assistance.

Elderly people can apply to their local authority if they wish to adapt their home and will be granted support in kind. There are no statistics available on the number of applicants. In the case of substantial renovation of rented accommodation and the construction of new buildings, it is required by law (under the Building Decree) that the building should be easily adaptable. This means that it should be possible, for example, to make a building wheelchair-accessible with minimum structural work. Local authorities can choose to offer people new or renovated housing if the cost of adapting their present home is too high, in which case a relocation grant is also available to help towards the cost of moving house.

j. The Committee notes that housing associations established under the Subsidised Rented Sector (Management) Decree (BBSH) have the obligation to assist the elderly (as well as other persons requiring care and support) in providing them suitable housing. The Committee asks for more detailed information on this assistance, and asks whether there are compensation mechanisms for the elderly to meet the costs of private rental housing (housing allowance, low-price housing, etc.).

Housing associations have an explicit duty to house the elderly and other vulnerable groups. As stated in the question, this is governed by the Subsidised Rental Sector (Management) Decree (BBSH). All associations must report annually to the Minister of the Interior and Kingdom Relations on how they have fulfilled their obligation, and are assessed on their performance. A full report is then submitted to the House of Representatives.

In providing suitable housing for these groups, associations usually have an unprofitable margin, which they do not expect to recoup in rents. As a result, rents can be kept relatively low. Anyone with a low income and a relatively high rent (up to a maximum of €664 per

month) can also apply for housing benefit in the Netherlands. The higher a person's income, the lower the housing benefit.

k. The Committee asks for information in the next report on: health care programmes and services (in particular primary health care services) specifically aimed at the elderly; guidelines on health care for elderly persons if any; and palliative care services for the elderly.

The National Programme on care for the elderly is designed to improve the quality of care provided to older people with complex needs. Many national and regional organisations have joined forces with the aim of ensuring that supply is better matched to individual demands. A three-stage plan is gradually being implemented:

1. creation of regional networks;
2. development and implementation of projects and pilot schemes;
3. dissemination and application of know-how.

The programme was launched in April 2008 and the final results of the eight regional networks and 75 projects are expected in 2013 and 2014.

The Ambient Assisted Living Joint Programme, which began in 2008 and will run until the end of 2013, focuses on ICT solutions that enhance the quality of life of older people and enable them to lead independent lives for as long as possible, while also making up for the expected shortfall of care staff.

The aim of the 'Visible link' *(Zichtbare schakel)* programme (2009-2012) is to make better use of district nurses in promoting a healthy community. In 2011, 160 district nurses (FTEs) were involved in 90 projects.

Guidelines
- Appropriate diabetes care for vulnerable older people
- Dealing with behavioural problems associated with dementia
- Incontinence care for vulnerable older people
- Chronic pain care for vulnerable older people
- Oral hygiene services for care-dependent clients in nursing homes

Palliative care
Good palliative care is holistic care for patients with an incurable disease, focusing on the treatment of pain and other physical, psychosocial and spiritual problems. Palliative care is also characterised by a proactive approach and continuity of care, regardless of the status of the patient (inpatient, outpatient or a mixture of both). It is vital for ensuring quality of life for people nearing the end of their lives and to help them die with dignity. The care provided is patient-centred and is based as much as possible on the needs and preferences of the patients and their families. The Dutch government takes the view that it is important for people to be able to choose where they spend the end of their lives. Often they prefer to die at home, but sometimes this is not possible, for various reasons. A good standard of care can then be offered in a hospice, hospital, nursing home or residential home for the elderly.

Palliative care services are integrated into mainstream care wherever possible. The key providers are primary health professionals such as GPs, district nurses, care workers and doctors in nursing homes and hospitals.

l. As regards persons with dementia and related illnesses, the Committee notes from the EU Peer Review that the necessity to improve dementia care and to strengthen the position and support for informal carers is recognised by the authorities. It asks in this respect what is being done in this field to improve the situation.

A programme aimed at providing integrated multi-agency, demand-driven care for dementia patients began in March 2008. By late 2011, when the programme came to an end, there was a near-nationwide network of regional organisations working together to deliver the care required in a structured way. Internationally, the Netherlands is involved in the coordinated development of scientific research on dementia (especially Alzheimer's) as part of the Joint Programme – Neurodegenerative Disease Research (JPND), and in sharing expertise on dementia care as part of the Joint Action on Alzheimer's (ALCOVE) project.

m. The Committee nevertheless notes from the EU Peer Review that the quality of care in nursing homes has received considerable criticism. A number of measures have been taken to tackle this problem, such as large scale improvement programmes, a better inspection policy and the formulation of performance indicators (aiming at quality of life). The indicators started being implemented in 2008. The Committee asks to be kept informed on the implementation of these different measures.

The September 2010 coalition agreement/parliamentary support agreement includes a section on strengthening the rights of residents in care institutions. This is addressed in a bill relating to care provided under the exceptional medical expenses scheme, which is currently before Parliament. Under this new legislation, any discussions about a care plan must always include a number of specific topics.

The aforementioned agreement also states that a quality standards institute will be set up for the entire healthcare sector.

With regard to care for the elderly (residential homes for the elderly, nursing homes and home care), both quality of care and client satisfaction have been measured over a number of years. Each year the sample set is evaluated and the indicators and questionnaire are reviewed. The findings are used for several purposes: as supervision data for inspections, purchasing information for care buyers, and to enable clients to make the right care choices. In autumn 2011 the organisations involved concluded that the method used generates insufficient information, and are now looking at whether there is a better way to improve quality and make it more transparent (this is an ongoing process, as the best solution has yet to be decided).

n. As regards the Health Care Inspectorate (IGZ) which monitors compliance with care standards in institutions, the Committee asks how this body is composed and if it has powers to inspect both public and private nursing homes. It recalls in this respect the importance of ensuring that any inspection system be independent (preferably an Ombudsman type institution).

General

The Dutch Healthcare Inspectorate (*Inspectie voor de Gezondheidszorg* - IGZ) promotes public health through effective enforcement of quality standards with regard to health services, prevention measures and medical products. It advises the responsible ministers and employs various tactics, including advice, encouragement, pressure and compulsion, to ensure that individual healthcare professionals and healthcare institutions provide 'responsible' care

with respect to quality and patient and client safety. The Inspectorate investigates and assesses in a conscientious, expert and impartial manner, **independent** of party politics and **unaffected** by the current care system.

Methods
Phased supervision: this is the method by which the Inspectorate ensures efficient and effective enforcement of the legislation for which it is responsible. First, the Inspectorate identifies where the greatest risks to the quality of care lie. By means of inspection visits and/or enforcement action, it then prompts care providers to make the necessary improvements.
The three phases involved are as follows.

- 1. Identification of risks based on an analysis of quality data and any additional information about care providers and care services. This is in preparation for the second phase.
- 2. Inspection visits, assessment and selection of appropriate measures. The Inspectorate visits nursing homes, sometimes unannounced and occasionally using 'mystery visitors', takes a look around and talks to management, employees and, if possible, patients or their families. It prepares a record of every visit and, if any risks are identified, asks the management to take appropriate measures.
- 3. Imposition of administrative or disciplinary measures, or institution of criminal proceedings where appropriate.

Incidents: reports of incidents, unsatisfactory situations and ongoing shortcomings play an important part in the Inspectorate's supervisory and enforcement activities. Some reports may prompt the Inspectorate to take immediate enforcement action. All reports are an important source of information regarding the quality of care.
If the Inspectorate receives a report (from staff, patients or relatives) that suggests serious shortcomings in the quality of care, or less serious shortcomings that are nevertheless of an ongoing nature, it will take enforcement action. The measures available range from advice and encouragement to correction or compulsion.
The Inspectorate analyses all incoming reports, using the results to substantiate its opinion regarding the quality of care in the various sectors of the healthcare system. It may also choose to further investigate specific reports during its inspection visits.

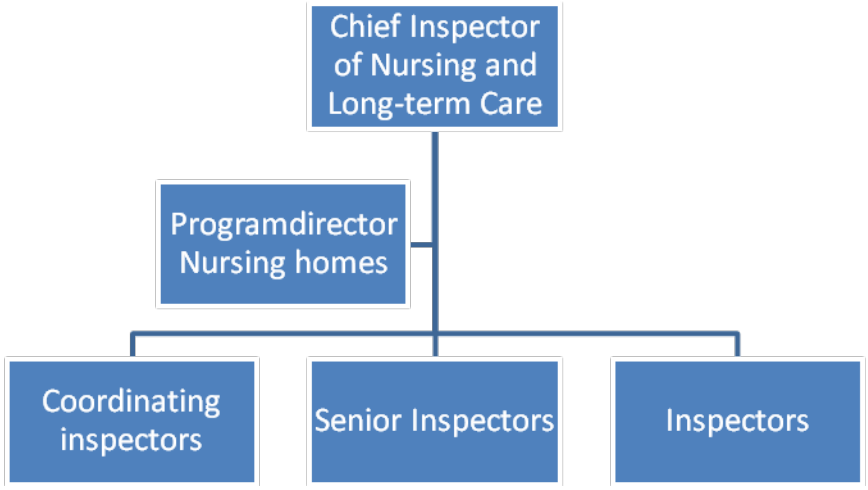
Not every report is investigated by the Inspectorate
In order to maintain its efficiency and effectiveness, the Inspectorate does not investigate all incoming reports itself. In many cases, it will ask the care provider concerned to conduct an internal investigation and submit a report. The Inspectorate does, however, impose certain conditions with regard to the quality and thoroughness of internal investigations.
In exceptional cases, the Inspectorate will conduct its own investigation in response to an incoming report, i.e.:

- in the event of an extremely serious situation with an exceptionally high risk;
- if it believes that its own investigation will improve quality right across a particular healthcare sector;
- if the care provider concerned is not deemed capable of conducting a satisfactory internal investigation;
- if the report submitted by the care provider does not meet the required standards;
- in cases of significant public interest.

Theme-based monitoring: this is the method used by the Inspectorate to investigate specific matters in nursing homes, based on reported incidents and phased supervision. In recent years

the Inspectorate has investigated restraint and the safety of the use of medicines. It has also looked at market newcomers providing nursing care in private nursing homes.

The Inspectorate is organised for nursing homes as follows:



Programdirector: Programme Director

o. Finally, the Committee also asks if the current capacity in institutional care in general meets the demand for places in these structures.

During the period 2007-2010 more than 400,000 people aged 65 and over made use of elderly care services. There is a set waiting time norm that is socially acceptable, with about 90% of older people receiving care within this norm and around 10% exceeding it. Occasionally an elderly person voluntarily turns down care, but sometimes people have to wait longer than desirable because of a specific capacity shortage, particularly in the case of older dementia patients with complex care needs. Generally speaking, access to care for the elderly can be regarded as good.

Article 30 – Everyone has the right to protection against poverty and social exclusion

With a view to ensuring the effective exercise of the right to protection against poverty and social exclusion, the Parties undertake:

a. to take measures within the framework of an overall and co-ordinated approach to promote the effective access of persons who live or risk living in a situation of social exclusion or poverty, as well as their families, to, in particular, employment, housing, training, education, culture and social and medical assistance;
b. to review these measures with a view to their adaptation if necessary

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The National Reform Programmes for 2008-2010, 2011 and 2012, and the National Strategic Reports for 2008-2010 (social protection and inclusion), 2009 and 2012 all contain references to the legal framework relating to the right to protection against poverty and social exclusion. Under Article 13 of this ESC report you will also find a description of the general statutory framework underpinning the Dutch social security system.

In the 2008-2011 period, efforts were made to ensure social protection and inclusion by strengthening social cohesion. Participation was a key concept. Encouraging employment among all population groups had high priority.

In 2007, two specific policy priorities were identified to combat poverty and social exclusion:
- more scope for municipalities to pursue targeted poverty reduction policies (policy priority 43);
- reducing the waiting lists for debt relief assistance to a minimum by 2011 (policy priority 44).

These objectives were continued until 2010.

The 2008, 2009 and 2010 annual reports of the Ministry of Social Affairs and Employment document on the objectives, concrete measures, projects and achieved results relating to combating poverty and social exclusion

2010 was the European Year for Combating Poverty and Social Exclusion. In the Netherlands, a special effort was made to encourage close cooperation between municipalities and civil society organisations. This led to various activities as an extension of the Dutch anti-poverty policy. The Ministry of Social Affairs and Employment's annual report for 2010 and the National Programme for the European Year provide an overview of events, campaigns and products.

In 2010, as part of the Europe 2020 strategy, a new objective was adopted which aims at the reduction of the number of households with a low work intensity by 100,000 (see National Reform Programme (NRP) 2011). Chapter 5.5 of the NRP 2012 examines in more detail the

statutory framework for activities as of 2011, the EU 2020 goal of 'reducing the number households with a low work intensity' and the effects of the proposed measures on the people in or at risk of poverty and social exclusion.

Chapter 2 of the National Strategic Report (NSR) 2012 specifically examines developments in policy in the following fields:

- comprehensive support by municipalities for vulnerable citizens and help finding employment;
- the minimum wage and social assistance;
- preventing people becoming homeless;
- help with debt problems
- children;
- early childhood education.

3) Please provide pertinent figures, statistics or any other relevant information: on the nature and extent of poverty and social exclusion, including the number of persons or households who are socially excluded or live in poverty; and on the methodology followed or criteria used to measure poverty and social exclusion, bearing in mind that the Eurostat at-risk-of-poverty rate before and after social transfers is used as a comparative value to assess national situations.

In terms of people at risk of poverty or social exclusion, the Netherlands occupies a relatively favourable position within Europe. To measure how many people are at risk of poverty according to the European definition, the following three indicators are used.

- The 'at-risk-of-poverty rate'. This is the most commonly used indicator. It shows how many people have an income lower than 60% of the median. Median income marks the halfway point in income distribution: 50% of the people in a country have an income higher than the median, 50% have an income lower than the median.
- Material deprivation: this indicator shows how many people are unable to afford more than four items or activities out of a list of nine, such as a washing machine or pay their gas/water/electricity bills.
- Jobless households: this indicator shows how many people in the 0-59 age group live in a household with a low work intensity. All members of households with a work intensity lower than 0.2 count as poor and excluded. To illustrate: a family with two adults, one of whom has a job, has a work intensity of 0.5.

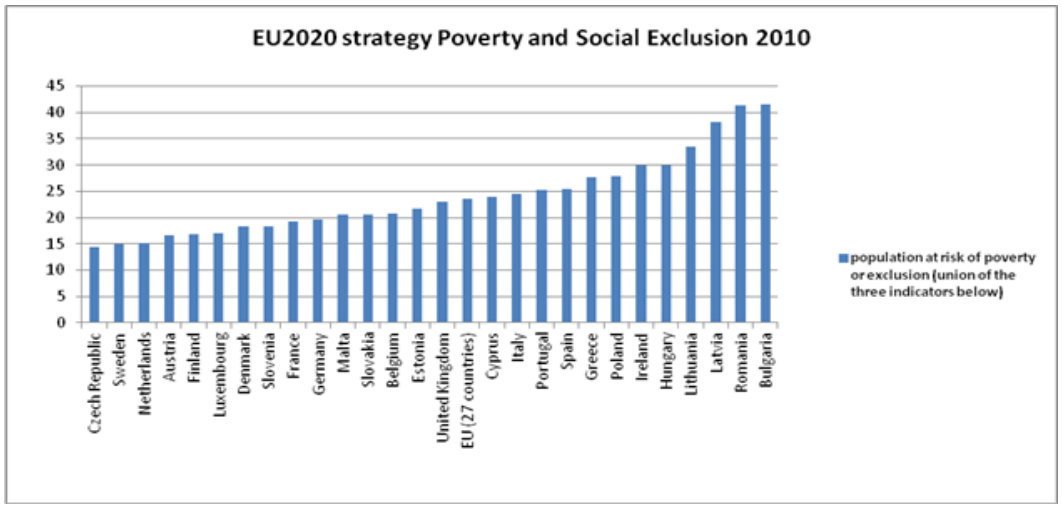
Table 1: Position of the Netherlands by indicator, 2010

Indicator	at-risk-of-poverty rate	material deprivation	jobless households
% of the population	10.3 (in 2009 11.1)	2.2 (in 2009 1.4)	8.2 (in 2009 8.3)
Score within Europe	2nd (in 2009 4th)	3rd (same as in 2009)	12th (in 2009 21st)
Average EU27	16.2 (in 2009 16.4)	8.1 (same as in 2009)	10 (in 2009 9)

(Source: Eurostat)

Table 1: The Netherlands scores well on the material deprivation indicator due to special assistance and other interventions by the municipalities. The Netherlands also scores well on the 'at-risk-of-poverty' indicator. This has to do with the relatively high minimum wage and relatively generous welfare benefits. A relatively high proportion of people have a low work intensity (jobless households), though their income is not below 60% of the median (at-risk-of-poverty).

There is an overlap between these groups, so that a total of ***15.1%*** of the population of the Netherlands (2010) fall within the new EU poverty criterion (at risk of poverty and social exclusion). For the record, this is the same percentage as in 2009.



(Source, Statistics Netherlands: http://www.cbs.nl/nl-NL/menu/themas/inkomen-bestedingen/publicaties/artikelen/archief/2012/2012-3556-wm.htm/English)

The Netherlands is on track as far as the 'jobless households' indicator is concerned. The table below presents the results of developments known to date. The number of people living in households with a low work intensity rose between 2008 and 2009. However, given that in 2009 the countryfaced the biggest economic downturn in decades (the economy shrank by 4%), this rise may be regarded as fairly limited. In 2010 there was a noticeable drop, relative to 2008 and 2009

Table: Jobless households indicator

(1000s of people)		**2008**	**2009**	**2010**	**2018***	*
People in a household with low work intensity	0-64	1,613	1,641	1,595	1,513	-100

(Source: Statistics Netherlands)
**target value in 2020 (when figures to 2018 are known)*

The 2010 and 2011 Poverty Monitor (*armoedesignalement*) present the figures up to 2010. The 2011 edition provides estimates for 2011. The exact figures for 2011 will not be available until the end of 2012.

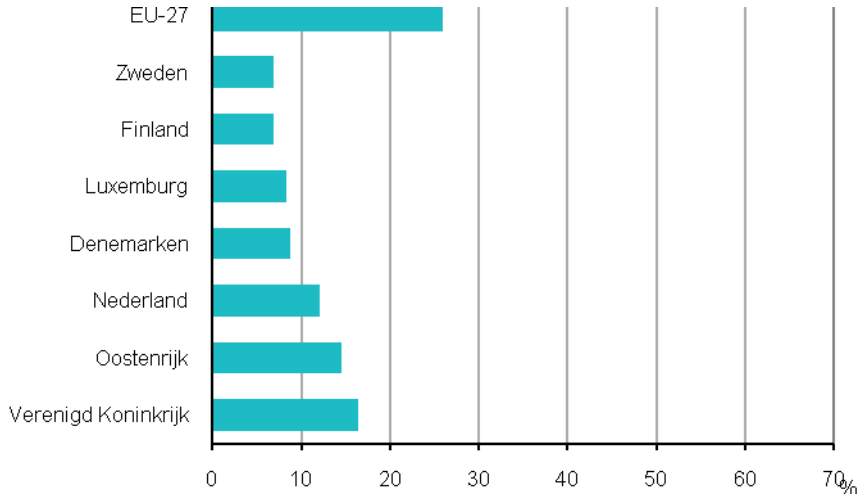
The most recent figures:
In 2010 the risk of poverty remained the same based on the low-income threshold as an indicator (7.7% of the total number of households in both 2009 and 2010), but rose according to the 'modest but adequate criterion ' as an indicator (from 6.1% of the total number of persons in 2009 to 6.5% in 2010). The discrepancy in the figures produced by the two indicators is due to the fact that the 'modest but adequate criterion' threshold rises faster than inflation.
The poverty threshold in the overview given below is the low-income threshold. Its baseline is the level of social assistance benefit in 1979, adjusted for inflation.

	1990	1994	2000	2005	2009	2010
Percentage of households with an income below the poverty threshold	15.0%	16.1%	11.8%	9.9%	7.7%	7.7%
Percentage of households with an income ***persistently*** below the poverty threshold			5.4%	3.5%	2.6%	2.4%
Percentage of children living below the poverty threshold			15.0%	12.7	9.9%	10.1%
Percentage of children living ***persistently*** below the poverty threshold			5.6%	4.3%	3.7%	3.7%
Percentage of employees with an income below the poverty threshold			4.6%	3.7%	3.8%	Less than 4%
Percentage of self-employed workers with an income below the poverty threshold			13.0%	12.2%	12.1%	13.7%
Percentage of self-employed workers with an income ***persistently*** below the poverty threshold				2.4%	2.8%	2.8%

(Source: Netherlands Institute for Social Research (SCP) and Statistics Netherlands, December 2011, income figures)

12% of people in the Netherlands say that they find it hard to make ends meet with their disposable income. This percentage was lower only in Finland (7%), Sweden (7%) and Luxembourg (8%). The average in the EU-27 is 26%. The figures relate to a subjective assessment by the individuals themselves.

Persons finding it (very) difficult to make ends meet in 2010 (source: Eurostat)



Sweden, Finland, Luxembourg, Denmark, The Netherlands, Austria, United Kingdom

Questions from the European Committee of Social Rights

arising from the Netherlands' previous report (21st)

a. *The Committee recalls that Article 30 does not only cover poverty but also social exclusion and the risk of social exclusion. It asks that the next report indicate how this phenomenon is tackled.*

The reports and annual reports referred to provide information on policy and figures relating to both poverty and social exclusion.

Sources:
National Reform Programme 2008-2010 :
http://ec.europa.eu/social/keyDocuments.jsp?policyArea=&type=0&country=28&year=2008&advSearchKey=&mode=advancedSubmit&langId=en

National Reform Programme 2011
http://ec.europa.eu/europe2020/pdf/nrp/nrp_netherlands_en.pdf

National Reform Programme 2012
http://ec.europa.eu/europe2020/pdf/nd/nrp2012_netherlands_en.pdf

National Strategic Report 2008-2010
http://ec.europa.eu/social/keyDocuments.jsp?policyArea=&type=0&country=28&year=2008&advSearchKey=&mode=advancedSubmit&langId=en

National Strategic Report 2009
http://ec.europa.eu/social/keyDocuments.jsp?policyArea=&type=0&country=28&year=2009&advSearchKey=&mode=advancedSubmit&langId=en

National Social Report 2012 (not yet online)

National Programme for the European Year of Poverty and Social Exclusion
http://ec.europa.eu/social/main.jsp?catId=808&langId=en

Healthcare services: Country Report for the Netherlands 2008 (National Institute for Public Health and the Environment)
http://ec.europa.eu/social/keyDocuments.jsp?policyArea=&type=0&country=28&year=2008&advSearchKey=&mode=advancedSubmit&langId=en

Health Care Performance Report 2010
http://www.gezondheidszorgbalans.nl/object_binary/o10229_DHCPR-2010(def)[1].pdf

Armoedesignalement 2010 en 2011 (Poverty Profile 2010 and 2011)(in Dutch only)
http://www.scp.nl/english/Publications/Summaries_by_year/Summaries_2011/Poverty_Survey_2011
http://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2010/Armoedesignalement_2010/Armoedesignalement_2010

SGBO Benchmarking: Benchmark armoedebeleid 2011 (Poverty policy benchmark 2011) (in Dutch only)

http://www.divosa.nl/sites/default/files/eindrapport_benchmark_armoedebeleid_2011_anoniem.pdf

b. The Committee asks for more information in the next report about the impact of any measures taken in terms of reducing poverty and, in particular, social exclusion. More specifically, it asks what has been done to integrate the various benefits and services across the policy areas referred to in Article 30, such as employment, housing, training, education and culture, and asks for quantified indicators of the means deployed, the number of beneficiaries and the results achieved for each of the measures concerned.

The National Reform Programmes, National Strategic Reports and annual reports referred to above provide information about measures taken to reduce both poverty and social exclusion.

In addition, the following documents provide more information about social inclusion:
-Joint report on social protection and social inclusion (2009)
ec.europa.eu/social/BlobServlet?docId=3754&langId=en
-CBS: *Lage inkomens, kans op armoede en uitsluiting* (Low incomes, at risk of poverty and exclusion) (2009) (in Dutch only)
http://www.cbs.nl/NR/rdonlyres/E688BD27-5B14-402F-923A-F4A07235BD43/0/2009v51pub.pdf
-CBS: *Het nieuwe criterium voor armoede en sociale uitsluiting in de Europese Unie* (The new criterion for poverty and social exclusion in the European Union) (in Dutch only)
http://www.cbs.nl/NR/rdonlyres/2EADFC79-F0B1-4B2A-862E-C944BBD5670E/0/2011k4v4p30art.pdf

The reports (NHP and NSR) also provide an overview of measures in the field of employment, education, housing and care:
-The NSR 2009 provides an overview of how the Netherlands uses structural funds in various policy areas to promote broad participation. The report gives an overview of objectives, measures and (desired) results.
-Chapter 4.4 of the NHP 2011 discusses the national objective adopted in 2010 for education. Chapter 4.5 provides further information on the national objective for social inclusion.
-Chapter 3 of the NSR 2012 factors the theme of homelessness into social inclusion and gives further information on the Plan of Approach for the prevention of homelessness and care of the homeless that was launched in 2008.
-The National Programme for the European Year for Combating Poverty and Social Exclusion describes the objectives and the programmes developed and implemented in cooperation with, among others, the Ministries of Health, Welfare & Sport and of Education, Culture & Science.

The Dutch Health Care Performance Report describes the performance of the Dutch healthcare system. Go to http://www.gezondheidszorgbalans.nl/algemeen/menu/english/ for the most recent report (2010).

c. *The Committee asks for information in the next report, backed up by practical examples, on how individuals and voluntary associations take part in assessing measures to combat poverty.*

The government-wide policy on reducing poverty and promoting participation calls for the

support and efforts of many actors. Within the context of the National Action Plan Poverty Eradication and Promoting Participation extensive consultations had been held with various civil society organisations, research and advisory institutions and professional organisations as well as with municipalities and the social partners.

Organisations involved in government policy on poverty reduction and social inclusion include, among others: Stimulansz, Humanitas, DIVOSA, NIBUD, European Anti Poverty Network Nederland, the Dutch Centre for Social Development Movisie, the Council for Work and Income, Sociale Alliantie, and the Labour Foundation.

By way of illustration, a report by SGBO Benchmarking on municipal poverty reduction policy is enclosed. SGBO Benchmarking regularly performs studies across the entire public sector.