NETHERLANDS REPORT 2015 (1 JULY 2014 TO 30 JUNE 2015) EUROPEAN CODE OF SOCIAL SECURITY

I GENERAL

No *important changes during the report period*

A. Administration/Organization

No important changes during the report period

B. Benefits

See new rates from 1-1-2015 in the relevant chapters in this report.

II MEDICAL CARE

A. Health Insurance Act (Zorgverzekeringswet (Zvw))

- *Indexation of the compulsory deductible*
  For 2015, the yearly indexation of the compulsory deductible led to a raise of €15. The compulsory deductible is set at €375 in 2015.

  Types of health care which are exempt from the compulsory deductible:
  - General practitioner care
  - Obstetric care
  - Maternity care
  - Care related to certain chronic illnesses (Diabetes type 2, COPD, CVR)
  - District nursing services
  - Care and travel costs related to organ donation
  - All types of health care delivered to children under the age of 18

- *Reform of the Compulsory deductible compensation scheme (Compensatieregeling Eigen Risico (CER)) and of the Compensation for the chronically ill Act (Wet tegemoetkoming chronisch zieken en gehandicapten (Wtcg))*
  As of 1 January 1st 2014 both the CER and the Wtcg have been repealed. The provisions of these acts have been transferred to the Social Support Act (Wet maatschappelijke ondersteuning (Wmo 2015)). With this transition the administration has been transferred from the national government to the local governments at municipality level.

  The reason for this change is that often people whom the schemes were not intended for received the benefit, as a result of the criteria under the CER en Wtcg-schemes. For example, it turned out that in practice often chronically ill people who had structural additional expenditures did not receive the benefits. At the same time incidentally ill people received the benefits.

Due to their proximity to the individuals, local governments are in a better position to assess who is eligible for the benefit in question and who is not. This way the benefits reach the right people.

- *Changes in the basket of care*

  Several types of benefits in kind have been transferred to the Health Insurance Act as a result of the repeal of the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten (AWBZ)). See paragraph B for more information on the long-term care reform:
  - Care related to sensory disabilities.
  - District nursing services.[1]
  - Personal care budget for district nursing services.
  - The second and third year of treatment-focussed intramural mental health care.

  Other changes to the basket of care as of January 1st 2015 (unless another date is stated):
  - Changes have been made to different types of prenatal screening available in the basket of care. The combination test (blood examination and ultrasound imaging) for pregnant women is only available on medical grounds (e.g. genetic predisposition or previous child with one of the symptoms to be examined). Up until December 31st 2014 the combination test was also available to all pregnant women of 36 years and older. The Health Council of the Netherlands however has advised that there is insufficient reason to treat pregnant women 36 years and over different than younger pregnant women and has advised that the combination test available on medical grounds suffices.

    The Non-Invasive Prenatal Screening (NIPT) has been added to the basket of care for pregnant women who should receive it on medical grounds or who received positive results on the combination test.

    Lastly, invasive diagnostics are only available to those who received positive results on either the combination test or the NIPT. For the same reason as above this has been removed for pregnant women 36 and over without medical grounds.
  - HIPEC, a specific type of chemotherapy, has been conditionally accepted for a period of 4,5 years from April 1st 2015 onwards. The final decision on full acceptance will be made after these 4,5 years and will depend on the effectiveness of the treatment shown in the results of the study.
  - Transport costs made by the organ donor will now be reimbursed by the health insurance company of the organ donor rather than the health insurance company of the organ recipient.
  - The conditions for receiving geriatric rehabilitation have been modified. Until December 31st 2014 patients had to enter geriatric rehabilitation immediately after leaving the hospital. As of January 1st 2015 entry into geriatric rehabilitation is now possible up to a week after leaving the hospital.
  - Dyslexia care has been removed from the basket of care.[2]

[1] These services were transferred to the Health Insurance Act to centralise all district nursing services under one Act. The measure is aimed at allowing individuals to stay at home for as long as possible.

[2] Dyslexia care has been transferred to the Youth Act (Jeugdwet). The reason for this transfer is that dyslexia care is often provided by (youth) mental care providers who are reimbursed through the Youth Act. Coupling these types of care under one Act minimises the administrative burden.

B. Long-term care reform and the repeal of the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten (AWBZ)).

The Netherlands has introduced a number of major reforms in the long-term care system to ensure that care continues to be accessible to all, of good quality and affordable. The AWBZ has been repealed as of January 1st 2015. Entitlements under the AWBZ have been transferred to the 2015 Social Support Act (Wet maatschappelijke ondersteuning 2015 (Wmo 2015)), the Youth Act (Jeugdwet) or to the Health Insurance Act (Zorgverzekeringswet (Zvw)). A new piece of legislation has been created to cover the remainder: the Long-term Care Act (Wet langdurige zorg (Wlz)).

These policy reforms were necessary because of three closely related reasons.

First of all, when the AWBZ came into force in 1968 as a residence based social insurance scheme, it was meant to only cover exceptional, uninsurable health care costs. Over the years however, all different types of health care (costs) have been added to the insurance under the AWBZ that do not fulfil these requirements.
The Wlz, Zvw, Wmo 2015 and Jeugdwet together aim to provide a coherent legal framework within which health care can be delivered according to the desires, capabilities and needs of individual people.

Secondly, under the AWBZ long-term care has become highly institutionalised; increasingly more individuals were living in residential facilities with comprehensive care. A development that had driven the AWBZ away from what it was initially intended for (exceptional, uninsurable health care costs).
The new system aims to change this. The intention is to keep people in their own homes longer, responding to their personal situation and determining what they can still do themselves or with help from their social network, whenever necessary with support from the municipality or care provided under a care insurance scheme.

Finally, since its entry into force in 1968, the amount of people receiving care under the AWBZ has grown substantially and with that, the budget that is required to fund the AWBZ. In 1968 the amount of people receiving care under the AWBZ was projected at 0,6% of the total population. In 2012 the amount of people entitled to care under the AWBZ had risen to 5% of the total population.
The 2015 long-term care policy reform aims to ensure future solidarity of the system and care and support for the most vulnerable people in society.

Following these three considerations a new long-term care system has been set up based on the following four principles:

1. Quality of life: the starting point of the new system is to focus on people's capabilities rather than disabilities.
2. Taking care of each other: when one needs support, one's own personal network and financial capabilities come first in providing support.
3. For those who do not have the (financial) capabilities to support themselves, care and social support is always provided.
4. Those who need care, assistance and supervision permanently, are entitled to care under the Wlz.

In light of the principles above, the different types of care and social support previously part of the AWBZ have been reassessed. Depending on the (target) group the types of care and social support have been transferred to one of the four acts (Wmo 2015, Zvw, Jeugdwet, Wlz). This results in the following.

Changes as of January 1st 2015
The set-up of the new long-term care system has led to several changes as of January 1st 2015. As mentioned above, the AWBZ has been repealed. Entitlements that used to be part of the AWBZ have been transferred to one of the following four acts, depending on the nature of the entitlement.

- The Long-term Care Act (Wlz).
  Like the AWBZ, the Wlz is part of the social security system and all residents in the Netherlands are automatically insured, as are non-residents who work in the Netherlands. The insurance is financed through contributions. The new Act covers all forms of care for people with serious, long-term care needs who require intensive care or supervision at close hand 24 hours a day, such as vulnerable old people and people with severe disabilities. These might include elderly people with advanced dementia or people with a serious physical or mental impairment. The Act governs care in both institutions and at home. Benefits may be in kind, on the basis of a personal budget, or be made up of a combination of the two. Care is granted on the basis of a care needs assessment.

  To ensure a smooth transition, the starting point for the Wlz is that nobody is forced to leave a care institution he or she already lives in.

- The Social Support Act (Wmo 2015).
  The primary objective[3] of the Wmo 2015 is to enable individuals to live independently for as long as possible in their own homes and to participate in society. The Wmo 2015 differs from the Wlz in that the responsibilities for the execution and policy making of this act lie with the municipalities. Furthermore, the WMO 2015 is no social insurance but part of the welfare legislation in the Netherlands. Examples of support that fall under the Wmo 2015 are support for participation, support for independent living, support in cleaning the house and support for informal care.

  Furthermore, in the Wmo 2015 the right to this type of care, under certain conditions, is laid down, but the municipalities have a discretionary competence in choosing *how* they execute this act. It is not stipulated in advance what kind of provisions someone can apply for. The aim is to allow municipalities to 'tailor' the way care and support are provided for.

  Moreover, in assessing whether someone should receive tailored care or support, the municipalities will review the overall situation of the individual. They will assess whether and to what extent an individual's own social network or existing, commonly accessible, provisions can suffice in enabling the individual to live independently and participate in society. These circumstances are being considered by the municipality before a decision is being made. Clients can appeal the decisions if they disagree.

  In order to ensure a smooth transition period, the act contains a transitional arrangement: people who received care under the AWBZ which has been transferred to the Wmo 2015, have a right to receive the same care they previously received until December 31st 2015.

- The Youth Act (Jeugdwet).

[3] The Social Support Act 2015 also contains provisions concerning domestic violence, shelter for the homeless, etc.

All care because of a mental disorder, mental health care, parenting support and social support provided to children under the age of 18 have been decentralised under the Jeugdwet. Extension of the care provided under the Jeugdwet is possible up until the age of 23 if there is no other act that regulates the type of care provided.

Most entitlements to care for disabled children and young people previously part of the AWBZ have been transferred to the Jeugdwet. Moreover, entitlements to and provisions for youth related care under the Zvw (see *changes in the basket of care* above) and the old Wmo (social support and care provided by the municipalities) have been transferred to the Jeugdwet. Care that is covered by the Wlz or the Zvw, is not part of the Jeugdwet.

The execution of the Jeugdwet lies with the municipalities. The objective of the Jeugdwet is comparable to that of the Wmo 2015: children should be enabled to grow up in a healthy and safe way towards independency, self-reliance and participation in society; all dependent on their age and level of development.

- The Health Insurance Act (Zvw)
  See *changes to the basket of care* above for the relevant transfers.

III SICKNESS BENEFITS

No important changes during the report period

IV UNEMPLOYMENT BENEFITS

"Bridge"unemployment benefit

The government earlier reserved € 600 million to combat the labour market bottlenecks. Social partners at the sectoral level have the possibility to introduce proposals aimed at the tackling of concrete bottlenecks in districts and sectors which are qualifiying for public co-financing . These are so-called sectoral plans.

From January 1, 2015 a new claim period starts containing the bridge unemployment benefit as a supplementary measure. This measure should give unemployed persons the possibility to get faster a new job in the specific sector where a shortage of labour supply exists, for instance in the the technical industry.

In case an unemployed person starts working in a sector where such a shortage exists, that person receives an unemployment benefit, based on the hours during which he/she receives retraining, and a salary during the hours he/she is actually working. This reduces the transfer costs for the new employer. This measure applies to employees who are threatened with dismissal or to employees who are receiving an unemployment benefit.

V OLD AGE BENEFITS

The supplement on the AOW-pension, meant to provide for an extra financial contribution for the cost of living for pensioners, has been cancelled on January 1, 2015, and was replaced by a special income support based on the number of years that the pensioner has been living in the Netherlands, or for persons who are not living in the Netherlands but who are paying income taxes due to his/her employment in the Netherlands.

On April 1, 2015 the AOW supplementary allowance has been cancelled. The AOW supplementary allowance was an allowance on behalf of pensioners with a younger spouse who did not yet reach the pensionable age of 65, under the condition that only a limited income was received.

Pensioners who did already receive a supplement on April 1, 2015 will continue to do so, of course if all the benefit-conditions are met.

AOW pension rates as from 1 January 2015

You live on your own (you are single)

Monthly amount

	with tax credit	**without tax credit**
Gross *	€ 1,111.55	€ 1,111.55
Tax and national insurance contributions	€ 0.00	€ 206.67
Zvw contribution	€ 53.91	€ 53.91
Net	€ 1,057.64	€ 850.97

* The gross amount includes the AOW top-up of € 25.35. The gross amount excludes the holiday allowance. The holiday allowance is € 69.32 gross per month and is paid in May of each year.

You are married or living with a partner

Beneficiary and partner both receive an AOW pension

Monthly amount per person

	tax credit applied	**tax credit not applied**
Gross *	€ 765.95	€ 765.95
Tax and national insurance contributions	€ 0.00	€ 142.25
Zvw contribution	€ 37.14	€ 37.14
Net	€ 728.81	€ 586.56

* The gross amount includes the AOW top-up of € 25.35. The gross amount does not include holiday allowance. The holiday allowance comes to € 49.51 gross per month and is paid each year in May.

Partner does not yet receive an AOW pension; beneficiary does not receive a supplementary allowance

Monthly amount

	tax credit applied	tax credit not applied
Gross *	€ 765.95	€ 765.95
Tax and national insurance contributions	€ 0.00	€ 142.25
Zvw contribution	€ 37.14	€ 37.14
Net	€ 728.81	€ 586.56

* The gross amount includes the AOW top-up of € 25.35. The gross amount does not include holiday allowance. The holiday allowance is € 49.51 gross per month and is paid each year in May.

Partner does not yet receive an AOW pension; beneficiary receives a full supplementary allowance

Monthly amount

	tax credit applied	tax credit not applied
Gross *	€ 1,506.55	€ 1,506.55
Tax and national insurance contributions	€ 99.08	€ 279.50
Zvw contribution	€ 73.06	€ 73.06
Net	€ 1,334.41	€ 1,153.99

* The gross amount includes the AOW top-up of € 25.35. The gross amount does not include holiday allowance. The holiday allowance is € 99.02 gross per month and is paid each year in May.

*Partner does not yet receive an AOW pension; beneficiary's supplementary allowance is reduced by 10%***

Monthly amount

	tax credit applied	tax credit not applied
Gross *	€ 1,432.49	€ 1,432.49
Tax and national insurance contributions	€ 85.67	€ 266.08
Zvw contribution	€ 69.47	€ 69.47
Net	€ 1,277.35	€ 1,096.94

* The gross amount includes the AOW top-up of € 25.35. The gross amount does not include holiday allowance. The holiday allowance is € 94.07 gross per month and is paid each year in May.

** Since 1 August 2011, the supplementary allowance can be reduced by up to 10%. This reduction applies to households with a joint monthly income of € 2,627.56 gross or more.

How the benefit levels are composed

Gross
This includes the AOW top-up of € 25.35, but not the monthly amount for holiday allowance. The holiday allowance is paid in May.

Tax and national insurance contributions
The amounts are shown after deduction of tax credit as well as without deduction of tax credit. The amounts without deduction of tax credit apply if tax credit is deducted from other income.

Contribution Zorgverzekeringswet (Zvw)
This amount is 4.85% of the gross AOW pension.

Net
This is the amount that one actually receives each month.

Two basic rules
The amount of the AOW-pension depends on the living situation (see above); a single pensioner receives an amount of 70% of the net minimum wage, whereas a pensioner who is living together receives 50% of the net minimum wage. A person is considered to be living together if one is running a joint household. This means that two individuals share the same residence in the same building, share the costs of living and care for each other.
Concerning people who have a living apart together ("LAT")- relationship it sometimes was difficult to judge whether in fact a shared household existed and the two individuals were actually living

together.
That mostly depended on the personal situation, for instance the number of nights one was sleeping together. In order to clarify those rules, the so-called "two homes rule" has been introduced. In case both partners have their own place of living , they are considered to be living on their own, if the following conditions have been met:

*)Both partners are not married;

*)Both partners dispose of their own living (this may be rented or owner-occupied);

*)Both partners are registrated on their own address;

*)Each partner pays for all the costs and expenses for their own living

*)Each partner may freely dispose of his or her own living.

The advantage for these persons is that they receive a higher pension, namely 70% instead of 50% of the net minimum wage. The regulation entered into force on February 1, 2014.

VI WORK ACCIDENT AND OCCUPATIONAL DISEASE BENEFITS

Not applicable anymore

VII FAMILY BENEFITS

Legislation concerning the reorganisation of child benefits, entered into force on February 1, 2015. Purpose of the reorganisation is the simplification of the regulatory system, to stimulate labour participation and to provide for a financial supplement where this is most needed.
This new system consists of a maximum of 5 instead of 11 regulations: the child allowance, the child budget, the childcare benefit, the combinatorial reduction, and the providing of free schoolbooks. The providing of free schoolbooks is – contrary to the other regulations – no direct regulation regarding the parents, but this is carried out by the schools.

Financial compensation.

The child allowance and the child budget are meant as a financial compensation to parents with children. The child allowance is an independent income financial allowance on behalf of all families with children.
The child budget is an income-dependent and means-tested allowance for the costs of children, meant to support families with a low income. In the child budget, a distinction has been made between household-types. Single parents are entitled to a higher benefit, the so-called "single parent supplement". In this way the financial allowance to parents with lower incomes has been harmonised, without making any distinction between people with income out of employment and people receiving a benefit.
With the introduction of the single parent-supplement in the child budget, the previously existing supplements to single parents in the minimum wage and the previously existing fiscal arrangement aimed at single parents have been abolished.

The stimulation of labour participation

Apart from the regulations aiming at income support there are two regulations stimulating parents to start working, the combinational reduction and the child care benefit. The combinational reduction is a general fiscal allowance to parents, aimed to stimulate labour participation. which means that working is stimulated. The child care benefit is a specific allowance for parent to support the costs of formal childcare.

The allowance to parents with handicapped children ('TOG') has been abolished. This income-dependent allowance was meant for parents with children of 3 to 18 years old living at home with an AWBZ (Exceptional Medical Expenses Act)-indication of at least 10 hours per week.
The TOG has been integrated in the double child benefit from 1 January 2015. Parents with handicapped children living at home are entitled to two times the child benefit amount.

Child benefits
The child benefit- levels have not changed as from 1 July 2014. The amounts shown below are valid as from January 2015. The amount of the child benefit depends on the age of the child. One will get a higher amount when the child becomes 6, and again when the child becomes 12. Child benefit is paid every three months.

Dutch child benefit amounts, 1 January 2015 (in euros per three monts)

	0 -5 years old	6-11 years old	12-17 years old
Per child	€ 191,55	€ 232,71	€ 273,78

Twice the basic rate in the case of high expenses
If your child does not live at home, for example, because he or she is disabled, and if one is faced with high expenses, one may be eligible for child benefit at twice the basic rate.

VIII MATERNITY BENEFITS

No important changes during the report period

IX INVALIDITY BENEFITS

No important changes during the report period

X SURVIVORS'BENEFITS

Anw benefit levels (1 January 2015, in euros per month)

Survivor benefits

	With tax credit	Without tax credit
Gross	€ 1,154.66	€ 1,154.66
Tax and national insurance contributions	€ 236.83	€ 420.42
Net	€ 917.83	€ 734.24

* The gross amount includes the Anw top-up of € 16.65. The holiday allowance of € 83.56 gross per month is paid in May.

Survivor benefit for survivors who were receiving AWW widow's pension before 1 July 1996

	With tax credit	Without tax credit
Gross	€ 467.19	€ 467.19
Tax and national insurance contributions	€ 0.00	€ 169.17
Net	€ 467.19	€ 298.02

* The gross amount includes the Anw top-up of € 16.65. The holiday allowance of € 36.05 gross per month is paid in May.

Survivor benefit in a care relationship

One is considered to be in a care relationship if one:

- lives with someone because the other person needs extensive care, or
- lives with someone because one needs extensive care for him- or herself.

	With tax credit	Without tax credit
Gross	€ 747.55	€ 747.55
Tax and national insurance contributions	€ 89.00	€ 272.58
Net	€ 658.55	€ 474.97

* The gross amount includes the Anw top-up of € 16.65. The holiday allowance of € 59.69 gross per month is paid in May.

Orphan's benefit

For orphans up to age 9

	With tax credit	Without tax credit
	€ 380.81	€ 380.81
Tax and national insurance contributions	€ 0.00	€ 131.92
Net	€ 380.81	€ 242.89

* The gross amount includes the Anw top-up of € 16.65. The holiday allowance of € 26.74 gross per month is paid in May.

Orphan's benefit; 10 to 15 years

	With tax credit	Without tax credit
Gross	€ 562.89	€ 562.89
Tax and national insurance contributions	€ 21.67	€ 205.25
Net	€ 541.22	€ 357.64

* The gross amount includes the Anw top-up of € 16.65. The holiday allowance of € 40.11 gross per month is paid in May.

Orphan's benefit; 16 to 20 years

	With tax credit	Without tax credit
Gross	€ 744.98	€ 744.98
Tax and national insurance contributions	€ 87.42	€ 271.00
Net	€ 657.56	€ 473.98

* The gross amount includes the Anw top-up of € 16.65. The holiday allowance of € 53.46 gross per month is paid in May.

The amounts shown

Gross
This includes the Anw top-up of € 16.65 but not the holiday allowance. The holiday allowance is paid in May.

Tax and national insurance contributions
This shows the amounts after deduction of tax credit as well as without deduction of tax credit. The amounts without deduction of tax credit apply if tax credit is deducted from other income.

Net amount
This is the amount the beneficiary receives every month.

XI FINANCING

No important changes during the report period.

SPECIFIC REQUESTS IN THE DRAFT RESOLUTION REGARDING THE NETHERLANDS (JUNE 2015)

Specific request 1: Domiciliary visiting

The Committee invites the Government of the Netherlands concerning domiciliary visiting, to substantiate the above-mentioned statement and to provide proof, in its next report, that domiciliary visits are carried out in practice by supplying statistics on the number of such visits paid for, or reimbursed by, the private health insurers;

Answer Dutch Government

As stated in the 46th annual report, the entitlement to healthcare provided by general practitioners is laid down in article 10 of the Health Insurance act. The entitlement is further laid down in article 2.4 of the Royal Decree on health insurance. Domiciliary visits are included (and paid for) in this entitlement at the discretion of the general practitioner.

The Dutch healthcare authority's (NZa) most recent "market scan on general practitioner healthcare" (December 2012) gives insight into the amount of domiciliary visits per 100 patients per year. As can be seen in the table below the amount of domiciliary visits per 100 patients is fairly stable at around 6 visits per 100 patients per year.

Please note that these numbers are not percentages as some people have different types of visits with a general practitioner.

Type of visit	**2006**	**2007**	**2008**	**2009**	**2010**
At the Doctor's office	69,3	68,6	72,2	73,6	72,8
Domiciliary visits	5,7	5,6	6	6,8	6,2
Consultation via telephone	28,9	30,5	34,5	37,7	40,5

Source: http://www.nza.nl/104107/105773/475605/Marktscan_Huisartsenzorg.pdf page 16

Specific request 2: Promotion of the general health services

Concerning promotion of the general health services, with regard to Articles 10(4) and 49(4) of the Code, the Committee invites the Government:

1) to indicate in its next report whether such general health services are placed at the disposal of the insured persons by the public authorities or by the recognised private health insurers.

2) The Government is also asked to indicate whether the duty of care of the private insurers includes preventive care aimed at the maintenance and improvement of the health of the persons protected who are not suffering from the morbid condition;

Answer Dutch Government

With regard to the conclusion of the Committee that the Dutch health care system is a fully privatised health care system, the Government would like to underline that the Dutch health care system is a public system, consisting of five main Acts (see below). One of these Acts, the Health Insurance Act, is administered by private health insurance companies. It must be noted that this Act contains safeguards of a public nature, such as the obligation for all residents to take out health insurance, the obligation for health insurance companies to accept anyone who applies for insurance and to offer all insured persons the same insurance under the same terms.

With reference to the Committee's question concerning "general preventive health services", the Government, first of all, refers to the fact that the health (care) system in the Netherlands consists of five main Acts[4]. Each Act covers types of preventive care. In the Acts the collaboration between the administrators of the Act (local authorities and health insurance companies) is regulated to stimulate an integrated approach.

The Public Health Act and Health Insurance Act are mainly relevant to answer the Committee's question. In general, medical care services, including prevention for *individuals*, are covered by the Health Insurance Act, while general health services for the *whole population and specific groups at risk*, are part of the Public Health Act. This includes the early detection of individuals with high health risks.

1. General Health services for the Dutch population and specific groups at risk
The Public Health Act stipulates the responsibilities of the national government, in particular the Minister of Health, Welfare and Sport, and the local authorities to protect and promote the health of their inhabitants. The Netherlands has implemented the International Health Regulations (IHR) of the World Health Organisation (WHO) through this Act. Local authorities are obliged to establish a community health service (Gemeentelijke Gezondheidsdienst (GGD)) and have to stimulate the collaboration between the public health services and the medical curative care.

The main 'package' of public health services[5] offered by national or local authorities consists of:

- Infectious disease control, including the National Immunisation Programme for children[6] and the flue vaccination for people at risk;
- Medical hygiene and environmental care;
- Healthy child clinics and other services to promote children's health and youth health[7];
- Health promotion programmes focused on the main national health issues such as tobacco use, alcohol abuse, physical inactivity, overweight, diabetes and depression;
- National screening programmes for groups at risk, for instance heel prick test for newborns and cervical, breast and colorectal cancer screening programmes.

These services are mainly paid for through general taxation.

Conclusion
In reply to the Committee's first question: general health services are placed at the disposal of the insured persons by the public authorities.

[4] The Public Health Act (Wet publieke gezondheidszorg (Wpg)), Youth Act (Jeugdwet), Social Support Act (Wet maatschappelijke ondersteuning (Wmo)) are mainly administered by local authorities. The HealthInsurance Act (Zvw) is administered by private insurers. The Long-term care Act (Wet langdurige zorg (Wlz)) is administered by zorgkantoren (care offices).
[5] Not all are formally regulated in the Public Health Act.
[6] Through the National Vaccination Programme children are vaccinated against 12 different infectious diseases such as measles, mumps and diphtheria.
[7] This includes the provision of an infant welfare centre and regular health checks for children and adolescents.

2. Preventive health services for individuals
Primary care is a crucial element of the 'basic package' under the Health Insurance Act. This includes care which is provided by general practitioners and community nursing. These services are directly accessible for all insured persons with or without a morbid condition and therefore constitute an important aspect of prevention.

Specific preventive health services for individuals in the basket of care of the Health Insurance Act are mainly embedded in a medical setting and focus on individuals suffering from a morbid condition or individuals who are not suffering from a morbid condition but who have (high) health risks. The health insurance companies are obliged to provide the preventive services that are part of the 'basket of care' to their insured persons. The costs are mainly paid through premiums and co-payments by the insured persons. Examples of this type of prevention are preventive medicine for lowering cholesterol and blood pressure, individual personalised programmes to quit smoking and dietary advice, depression prevention (e.g. e-health or (group)sessions) and practical advice from professionals for patients with chronic conditions to prevent complications. Furthermore prevention can be part of a medical treatment, also in hospitals, when it is part of the professional standards of care.

Conclusion
In reply to the Committee's second question: the duty of care of insurance companies includes preventive care aimed at the maintenance and improvement of the health of persons who are suffering from a morbid condition as well as persons who are not suffering from a morbid condition.

Recent developments
The past years an increasing number of health insurance companies, in cooperation with local authorities have started creating local arrangements for specific groups at risk. In the arrangements collective and individual types of prevention are combined. Health insurance companies and local authorities have made agreements with regard to the (health) objectives to be achieved and the division of costs. This kind of cooperation can be focused on a particular health problem (for instance, overweight or diabetes) or disadvantaged neighbourhoods in which social and health problems cumulate.
The national government stimulates this type of cooperation and expects it to be a growing phenomenon. In 2015 the Ministry of Health investigates whether and how these initiatives can be structurally embedded in the health (care) systems.

Specific request 3: Effectiveness of medical care

Concerning the effectiveness of medical care, taking due note of the Government's statement that the experience of the Dutch population of having very good health between 2010 and 2012 is at a stable 80 per cent, the Committee invites the Government to substantiate this statement, in its next report, by reference to corresponding studies or sociological enquiries, if indeed no consistent statistical data on the health of the population is compiled by the Ministry of Health, Welfare and Sports.

Answer Dutch Government

The government will first reply to the question regarding reporting on the health status of the population (part a).

Subsequently, the government would like to make use of this opportunity to explain in more detail how the quality and effectiveness of the health care is assured (part b).

a. Reporting on the health status and effectiveness of medical care in the Netherlands

There is a statutory system in the Netherlands with regard to reporting on the health of the population. This system is laid down in de RIVM Act (Wet op het RIVM). The Minister of Health has commissioned the National Institute of Public Health and the Environment (RIVM) to periodically report on the current state of affairs and future developments in public health and health care in the Netherlands.[8] The RIVM is independent in choosing the research methods for these reports.[9] This is to ensure that research is scientifically relevant and internationally comparable.

Every four years, the RIVM publishes a report called (Gezondheids)Zorgbalans (Dutch Health care Performance Report). A second recurring report is the Volksgezondheid Toekomstverkenning (Public Health Status and Foresight Report) which provides a broad overview of the most important trends in Dutch public health with a focus on the future. The Dutch Health Care Performance Report 2014 can be downloaded from http://www.gezondheidszorgbalans.nl/English. The Key findings of the Dutch Public Health Status and Foresight Report 2014 can be downloaded from http://eengezondernederland.nl/en/English_version/Key_Findings. The Government refers the Committee to these reports. In the following section the government highlights a few relevant findings of these reports regarding the health of the population.

Relevant findings in the Dutch Health care Performance Report

With regard to the health of the Dutch population, as measured in terms of life expectancy, the Dutch Health Care Performance Report 2014 shows that the health of the population has improved since 1990, and especially in the first decade of the 21st century.[10] People live longer, and they live longer in good health. In diseases whose mortality rates are known to be influenced by health care, diagnosis-specific trends over time have shown improved health outcomes. These can be seen in overall mortality rates as well as in measures such as 30-day mortality (for cardiovascular diseases) and 5-year survival ratios (for cancer). Statistics like these are evidence for the positive value of health care in improving public health. International studies of the same diagnostic groups have confirmed that contribution.

The Report highlights numerous positive developments, as well as some issues for consideration. International comparison of quality indicators by the Organisation for Economic Co-operation and Development (OECD) has shown that the Netherlands scored above average on the majority of indicators when compared to other affluent countries. Results for more specific aspects of the

[8] On the basis of Article 3(1 sub b) of the RIVM Act.
[9] On the basis of Article 5 of the RIVM Act.
[10] RIVM (2014). Dutch Health Care Performance Report, p. 267

system were varied. On some indicators, the Netherlands ranked amongst the best-scoring countries: it had the lowest volume of primary care antibiotic prescription and a higher 48-hour surgery rate for hip fractures in comparison with many other countries. Scores on other indicators were less positive, including higher than desirable rates for mortality following strokes or acute myocardial infarctions and for perinatal mortality. Many quality indicators revealed favourable trends. For a complete picture, the Government refers to the Dutch Health care Performance Report 2014.

Relevant findings in the Public Health Status and Foresight Report
The sixth edition of the Public Health Status and Foresight report contains information on trends and prospects in public health and health care in the Netherlands. The situation is positive in many respects.

As a result of improvements in the health care system, Dutch people live increasingly longer. This has an effect on many areas of health care, in particular in the management of diabetes mellitus, pregnancy, cardiovascular disease and cancer. An estimated 40% of the total drop in mortality from coronary heart disease is accounted for by improved treatment options. A host of preventative measures formed another contributing factor in the rising life expectancy. A particularly positive effect came from anti-smoking measures, the increased use of drugs to reduce blood pressure and cholesterol levels, population screening, the elimination of trans fatty acids from foods and improved road safety. Things could be further improved by living healthier lives.

At the same time, more people have to live with long-term illnesses. One of the reasons of this development are the health care improvements; people who live longer are more likely to develop health problems. Diseases that used to be fatal at younger ages, such as diabetes and cardiovascular conditions, can now be managed in ways that allow people to grow increasingly older.

b. Further elaboration on quality assurance

First of all, the Government would like to state that the Government is highly committed to a high quality, accessible and affordable health care system. All insured persons in the Netherlands are entitled to a basket of care established by the government. Starting point is that the insured person must always receive care within a reasonable time and at a reasonable distance. Improving and further developing the quality of health care, as well as the affordability of health care is a continuous process and will continue to be a priority. The system under the Health Insurance Act offers various guarantees for the quality and effectiveness of medical care. A number of them are explained below.

The most important vehicle to *improve* the quality of care and to increase affordability is the system of contracting: health insurance companies agree on quality and price with the care providers. A contract between a health insurance company and a health care provider contains all different sorts of demands on for example the quality of care, following guidelines, providing service, waiting lists etcetera. The task of the health insurance company is to contract good quality care and good service for an affordable price on behalf of its insured persons. If a health care provider does not meet the quality criteria a health insurance company can choose not to contract this provider.

Furthermore, the legal framework for quality assurance by health care providers is laid down in the Quality of Health Facilities Act (Kwaliteitswet zorginstellingen / KZi), the Individual Health Care Professions Act (Wet Beroepen in de Individuele Gezondheidszorg / BIG) and the Medical Treatment Agreement Act (WGBO). To guarantee the quality of health care, the Quality of Health Facilities Act requires individual health care providers to provide 'responsible' care. In order to do so, health care providers have to set up a quality-system. The health care provided must meet the

needs of the individual patient and the health care has to be administered in an effective and efficient way. The Health Facilities Act requires health care providers to provide responsible care. The term 'responsible care' is not further defined by law as the Government takes the view that patients, health care providers and health insurers together know best what constitutes good health care. Moreover, the idea of what constitutes responsible care, can change over time. To allow for this type of reconsideration, some flexibility is necessary, something which cannot be achieved by fixing a definition in law.

In the Netherlands health care providers, health insurance companies and patients together set the guidelines. They do this for each type of disorder. The guidelines are registered with the Health Care Quality Programme of the Health Care Institute (Quality Institute). This Institute has a legal status. The registration process includes a screening on whether all stakeholder groups were included in the process of making the standard and whether a layman's version of the guideline is included. The register is publicly accessible. Finally, it should be noted that these guidelines, although not defined by government, do enjoy a legally binding status.

The Health Care Inspectorate (Inspectie voor de Gezondheidszorg (IGZ)) supervises the compliance to these guidelines. In its competence as the supervisory body for the inspection of the quality and safety of health care provided, the Health Care Inspectorate is the guardian of good quality health care. The Inspectorate supervises the quality of public health and ensures that health care providers are in compliance with the legal requirements and guidelines. The Inspectorate investigates complaints and irregularities in health care and takes measures if deemed necessary and appropriate. Complaints may give rise to a visit or an investigation to check whether guidelines and procedures are observed. The Inspectorate is competent to take measures in case quality standards are violated, such as ordering improvement within a certain time limit, imposing an administrative fine and/or tightening supervision. If a health care provider doesn't show enough improvement, the Inspectorate is –in the end– able to close down the practice.

As another aspect to assure the quality of medical care the Government would like to highlight the screening procedure for treatments or medicines. For a new treatment and/ or a medicine to become part of the basic package covered by the Health Insurance Act it has to go through a screening procedure. The screening procedure entails four criteria: (medical) necessity, efficacy/effectiveness, cost effectiveness and feasibility. The efficacy/effectiveness criterion screens new treatments/medicines as to whether they meet scientific and good practice standards. This ensures that only health care of high quality is part of the basic package under the Health Insurance Act. When part of the basic package, health insurance companies are expected to contract hiqh-quality, accessible and affordable health care on behalf of their insured persons.

In conclusion, the Government takes the position that legislation and practice in the Netherlands complies with Article 10, paragraph 3, of the Code. In this respect, the Government notes that from Article 10 (3) of the Code it follows that health care benefits are afforded to the persons protected by the Contracting Parties with an aim at maintaining, restoring or improving the health of the person protected and his ability to work and to attend to his personal needs. How this is achieved is the competence of the Contracting Party, provided that the legislation offers the benefits listed in Article 10 (1) of the Code.

Specific request 4: Participative management of the health insurance scheme.

- ***a. The Committee would like the Government to confirm that the above description is indeed its vision of how the national health insurance scheme should be organised and managed.***
- ***b. The Government is asked to specify the provisions in the statutes of the private health insurance companies which ensure that the policy of the Board and the general course of the company are properly monitored, and the insured persons are given the possibility to exert a fair degree of influence in this respect.***
- ***c. It is also requested to indicate whether the Dutch Health Care Authority has given any recommendations to that end, or has imposed sanctions on health insurers for failing to include such provisions in their statutes or to apply them in practice;***

Answer Dutch Government

a. It is the government's vision that insured persons should have a fair degree of influence on the course of affairs of their health insurance company. This is why Article 28, paragraph 2 of the Health Insurance Act stipulates that the statute of the health insurance company guarantees a fair degree of influence of the insured on their policy. Furthermore, Article 28, paragraph 1 of the Health Insurance Act prescribes that the statute of the health insurance company include provisions for monitoring the policy of the Board and the general course of affairs of the company.

   The Government is of the opinion that it complies with article 71(1) of the Code, both by legislation (article 28, paragraph 2 of the Health Insurance Act), and in practice (statutes and regulations of the health insurance companies): Article 71(1) of the Code stipulates that participation of the persons protected should be regulated, either through participation in management *or* in a consultative capacity. In practice, within all health insurance companies insured persons have a fair degree of influence on the course of affairs in *at least* a consultative capacity. The statutes of the health insurance companies are therefore in conformity with Article 71 (1) of the Code. The following information is of relevance:
   - All health insurance companies have a Council of Insured Persons or a Council of Members, which is composed of insured persons.
   - The majority of health insurance company groups are cooperative societies or guarantee societies. The highest body within these two types of societies, whose competences are laid down in the company's statute, is the Council of Members. In these companies the Council of Members has at least a consultative competence. In many cases, stipulated in the statute, the Council of Members has more competences. For example the competence to approve certain decisions of the Board, the annual accounts, the appointment or removal of members of the supervisory board, mergers or amendments to the statutes.
   - Three health insurance companies do not take the legal form of a cooperative society or guarantee society. These companies have a Council of Insured Persons that does have an advisory role (*consultative capacity*).

   Finally, the Government points out that according to Article 71(1) of the Code participation of social partners is optional, not mandatory.[11] As explained in the previous report, it is indeed the vision of the government that representation of the *social partners* in the governing bodies of health insurance companies does not match the way the Dutch health insurance system is organised. This is because health insurance companies insure *all* citizens, regardless of the fact whether they belong to the workforce or not.

11 According to Article 71 paragraph 1 national laws or regulations **may** likewise decide as to the participation of representatives of employers and of the public authorities. This is therefore no obligation.

Settlement of disputes
In addition, the Government would like to point out that there is a legal system in place for the settlement of disputes. If the decision is taken by a health insurance company not to reimburse a medicine or treatment, an insured person can ask the insurance company to *reconsider*.

If the insurance company fails to respond within a reasonable period of time or address the objections raised, the insured person may take the case to court or submit the dispute to an independent disputes arbitrator. The fact that the health insurance policy is a private agreement, means that, in principle, a dispute must be settled in accordance with civil law. This principle is embedded in Article 112, paragraph 1, of the Constitution of the Netherlands, which stipulates that the judiciary (i.e. the district/ sub-district court and, on appeal, the court of appeal) must rule in disputes concerning civil and personal rights and debts. In final instance, an appeal in cassation may be lodged with the Supreme Court.

As proceedings before a court of law take considerable time and are expensive, the insurance company and the insured person may jointly decide to refrain from approaching the civil courts and instead submit their dispute to an impartial third party.

Article 114 of the Health Insurance Act stipulates that a health insurance company must make it possible for its policy holders and insured persons to submit disputes about the performance of health insurance to an independent body. To this end, the Minister of Health Welfare and Sports has appointed the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ) as the competent independent foundation to handle complaints and disputes regarding health insurance. With this, the Netherlands has implemented the Directive 2013/11/EU on alternative dispute resolution for consumer disputes. The SKGZ meets European quality standards associated with this Directive.

The SKGZ consists of two parts: an ombudsman and a disputes committee. If the health insurance company reaffirms its decision and the insured person does not agree, the insured person can ask the ombudsman to mediate. If the ombudsman sees no possibility for mediation or if attempts to mediate fail, the insured person can submit a complaint to the disputes committee. Although the disputes committee's recommendations are in principle binding on all parties, the court can assess whether the law and the policy conditions have been applied correctly. If not, the binding recommendations are no longer considered valid. It costs money for the disputes committee to handle disputes. If the decision is in the insured person's favour, the health insurance company has to pay the costs.

b. *In Annex 1* the Government has specified the relevant provisions in the statutes of the health insurance companies that ensure that the policy of the Board and the general course of the company are properly monitored and the insured persons are given the possibility to exert a fair degree of influence in this respect. Further specifications are laid down in the regulations of health insurance companies.

c. The Dutch Health Care Authority (NZa) has not given any recommendations or imposed sanctions on health insurance companies for failing to include provisions regarding participative management in their statutes or to apply them in practice. There was never a reason for imposing a sanction.

Specific request 5: Determination of the reference wage

Concerning Part XI (Standards to be complied with by periodical payments), Articles 65 and 66 of the Code, Determination of the reference wage, the Committee notes that according to the previous reports of the Government, the reference wage of the standard beneficiary used to calculate the replacement level of benefits for Parts III, IV, and VIII of the Code is determined under Article 65 for the skilled manual male employee as the so-called "modal income" (modaal inkomen) in the Netherlands calculated by the Central Planning Bureau and for Parts V, VII, IX and X under Article 66 for the ordinary manual male labourer as the Legal Minimum Wage established by the Ministry of Social Affairs and Employment.

The Committee of Ministers points out that both methods used for determining the reference wage of the skilled employee and ordinary labourer do not correspond to any of the options allowed by Articles 65 and 66 of the Code and result in the case of Article 66 in establishing the reference wage manifestly below the wage of an ordinary adult male labourer calculated on the basis of Eurostat data by applying the option admitted in Article 66(4)(b);

Answer Dutch Government

In the Netherlands the periodical payments can be divided into three categories, namely the salary-related benefits, the minimum benefits and the family benefits. The Netherlands will apply Article 65 of the Code to the salary-related benefits, with exemption of part IX and article 66 of the Code to the minimumbenefits and the family benefits. This is shown in the table below:

Table 1

Art. 65 (6) b: a person deemed typical of skilled labour	A skilled employee of the ISIC rev. 4 group with the highest number of male employees: typical skilled male worker in manufacturing.	Part III, IV and VIII (Sickness benefit, Unemployment benefit and Maternity benefit)
Art 66(4) b: a person deemed typical of unskilled labour	An unskilled employee of the ISIC rev. 4 group with the higest number of male employees: typical unskilled male worker in manufacturing.	Parts V, VII, IX and X (Old-age benefit, Family benefit, Invalidity benefit and Survivors benefit)

Because of this division, this paragraph will be split into three parts, namely salary-related benefits, minimum benefits and family benefits. Each part will lead to a conclusion regarding the compliance to the European Code of Social Security. The time basis for all the amounts mentioned in this report is 1th of July 2015.

1. Salary-related benefits (art 65)
The salary-related benefits are related to the salary of the worker as shown in the table below:

Table 2

	percentage	Minimum benefit	Maximum benefit
Part III Sickness benefit	70%	€ 1628 per month[12]	€ 3044 per month[13]
Part IV Unemployment benefit	First 2 months: 75%; After that: 70%	€ 1628 per month[14]	€ 3044 per month
Part VIII Maternity benefit	100%	€ 1628 per month	€ 3044 per month

The salary-related benefits are related to the salary of the worker, within a range of a minimum and maximum benefit. Therefore it is not possible to use a proxy for the reference wage of the skilled workers. The salary-related benefit is raised with an allowance if the benefit is below the prescribed social minimum in the so called allowance law (Toeslagenwet). In this way a 'model family' is guaranteed a minimum income of at least the minimum wage level.

In the Dutch Code Report-2013 the Netherlands had interpreted the Dutch implementation of our reference wages in such a way that we use the so-called modal wage as a proxy for the wage of a skilled worker as mentioned in Article 65 of the Code and the minimum wage as a proxy for the wage of a unskilled worker as mentioned in Article 66 of the Code.
The Technical Note was reason to review our proxys. Here are the results of this review.

Article 65 (6) b describes the use of the reference wage of the typical skilled male worker in manufacturing. The standard is calculated on € 2718 per month. The time basis is 2010.
In the table below the prescribed standard is shown:

Table 3

	percentage	Reference wage	Outcome
Part III Sickness benefit	45%	€ 2718	€ 1223
Part IV Unemployment benefit	45%	€ 2718	€ 1223
Part VIII Maternity benefit	45%	€ 2718	€ 1223

[12] Minimum wage per month including holiday payment
[13] 70% of the maximum monthly wages.
[14] Staatscourant 2015 nr. 10678 20 april 2015

Conclusion:

Although the Netherlands don't use a reference wage in order to determine the salary-related benefits, the outcome (in terms of benefit level) is substantially higher than the European Code requires. The periodical payments of parts III, IV and V are based on the actual wages the workers earn within a range of a minimum and maximum benefit. The minimum benefit is equal to the minimum wage for a model household (Man, wife and two children) and lies well above the standard of € 1223.

2. Minimum benefits (art. 66)

The Ministry of Social Affairs and Employment uses the *net* Legal Minimum Wage to determine the periodical payments of the so called minimum benefits (excluding family benefit) as shown in the table below:

Table 4

	Percentage of net minimum wage	Outcome
Part V Old-age benefit	100%	€ 1586 gross per month[15]
Part X Survivors benefit	70%	€ 1224 gross per month

Table 5

The Invalidity benefit is related to the salary of the worker, within a range of a minimum and maximum benefit.

	percentage	Minimum benefit	Maximum benefit
Part IX Invalidity benefit	70% or 75% if the worker is > 80% invalide	€ 1628 per month	€ 3044 per month
Part IX sequel Invalidity benefit (vervolguitkering)	Between 28% and 50,75% of the minimum wage	€ 1628 per month	€ 1628 per month

Article 66 (4) b describes the use of the reference wage of the typical unskilled male worker in manufacturing. The reference wage is calculated on € 1928 per month. The time basis is 2010. In the table below is the prescribed standard shown:

[15] Including holiday payment

Table 6

	percentage	Reference wage	Outcome
Part V Old-age benefit	40%	€ 1928	€ 771
Part X Survivors benefit	40%	€ 1928	€ 771
Part IX Invalidity benefit	40%	€ 1928	€ 771

Conclusion:

Comparing the outcomes of table 4 and 5 and 6 leads to the conclusion that the Netherlands comply with the standard prescribed by the European Code of Social Security for the periodical payments described in part V, IX and X. The Netherlands also comply with the Code if Addendum 2 of the European Code of Social Security is applied on the parts V, IX and X as shown in table 7.

Table 7

	percentage	Reference wage	Outcome
Part V Old-age benefit	50%	€ 1928	€ 964
Part X Survivors benefit	50%	€ 1928	€ 964
Part IX Invalidity benefit	50%	€ 1928	€ 964

3. **Family benefits (art. 66)**

The family benefit (part VII) is the sum of a means-tested part and a part that is unrelated to the income earned. Table 8 shows the amounts of the income-unrelated part.

Table 8

0 up to and including 5 years	6 up to and including 11 years	12 up tot and including 17 years
€ 192 per month per child	€233 per month per child	€ 274 per month per child

The salary-related family benefit depends on the income of the worker and the number of children as shown in table 9:

Table 9

Number of children	**Family benefit**
1	€ 86 per month
2	€ 152 per month
3	€ 167 per month
4 and more	€ 167 + € 9 for every extra child per month

The amounts in table 8 are the maximum amounts when the workers' income is less than € 19767 per year. When the income is higher than this minimum income than the maximum amount is reduced with 6.75% of the income above € 19767.

The Netherlands spends on both types of family benefits together the amounts shown in table 10.

Table 10

Family benefits	Income-unrelated	Income related	Total
Netherlands	€ 3,215,604,000[16]	2,164,612,000	5,380,216,000

The standard according to art. 44 of the Code for the Family benefit is the total value of the benefits granted in art. 42 to the persons protected shall be 1.5% of an ordinary adult male labourer as determined in art. 66, multiplied by the total number of children of all residents. The standard is shown table 11:

Table 11

percentage	**Income art. 66**	**Number of children**	**Outcome**
1.5%	€ 1928	3,442,802[17]	€ 99,565,834

Conclusion:

In accordance to art. 44 the Netherlands should at least spend around 100 mln on family benefits. Reality is that the budget of the Netherlands for 2015 equals more than 5 billion a year.

[16] Source: Budget SZW 2015.

[17] Source: CBS; 1th of january 2014 the number of children of 0 years up to and including 17 years.

Overall conclusion:

In reply to the request we explained the methods used in the Netherlands to calculate the periodical payments and showed that these methods lead to a much higer outcome (in terms of benefit level) than the methods permitted by the Code require.
*Althoug the reference wage used according to art. 66 in the Code (€ 1928) is higher than the reference wage used in the Netherlands to establish the minimum benefits (€ 1628), the outcome (in terms of benefit level) of the formula: Percentage * reference wage is higher in the Netherlands, because of a higher percentage used, namely 100% of the minimum wage in the case of a model family[18].*

In the view of the Netherlands this leads to the conclusion that, leaving aside the instrumental level and measured at the level of 'desired outcome', we do comply with the standards regarding the reference wages of the European Code of Social Security.

Specific request 6: Structure and dynamics of poverty

Concerning social security and the reduction of poverty, in view of the fact that prevention and reduction of poverty is one of the main objectives of the Code, the Committee notes that further statistics are required on the structure and dynamics of poverty in the country.

Answer Dutch Government

Concerning social security and the reduction of poverty, we have been requested to provide the most recent and comprehensive statistics on the structure and dynamics of poverty in the Netherlands. The following aims to fulfill this request by providing:

1. An update of the data as mentioned in the 'Technical Note';
2. Additional data on poverty-groups based on the latest report of independent bureaus;
3. The policy priorities of the government in relation to poverty;

[18] Mainly due to the extra allowance of the so called 'Toeslagenwet' that increases the benefit up to 100% of the minimum wage in the situation of a family with both parents.

1. Update of Technical Note

The following update concerns data which we believe to be most accurate and relevant. In certain cases they may differ from the data in the original note, for instance with regards to the reference period. In footnotes an explanation is given for the choices made.

1. Eurostat

Indicator	Source	EU28 AVG		Netherlands	
		2012	2013	2012	2013
At-risk-of-poverty rate (AROP, % of total population)	ilc_li02	16,8	16,6	10,1	10,4
AROP for children (% of total children <18)	ilc_li02	20,5	20,2	13,2	12,6
In-work poverty rate	ilc_li04	9,0	8,9	4,6	4,5
AROP rate for pensioners	ilc_li02	14,6	13,8	5,5	5,5
Aggregate replacement ratio	tsdde310	54	55	47	47
Severe material deprivation (% of total population)	t2020_53	9,9	9,6	2,3	2,5
Persistent at-risk-of-poverty rate	ilc_li21	10,8	9,0	5,8	6,5
At-risk-of-poverty threshold (40%, single person)	ilc_li01	NA	NA	€ 685,4	€ 694,7
At-risk-of-poverty threshold (60%, single person)	ilc_li01	NA	NA	€ 1.028,1	€ 1.042,0

The risk of poverty or social exclusion in the Netherlands is relatively low compared to the other EU member states. Table 2 shows the position (in 2013) of the Netherlands in terms of the three EU indicators used to measure the risk of poverty and social exclusion.

2. Position of the Netherlands on the three indicators of the EU 2020 poverty target, 2013

Indicator	At risk of poverty[a]	Material deprivation	Jobless households (0-59)	At risk of poverty or social exclusion (AROPE, sum of the three indicators)
% of NL population	10.4	2.5	9.3	15.9
Ranking in Europe	2nd (after CZ)	3rd (after SE and LUX)	14th	2nd (after CZ)
% EU28	16.6	9.6	10.8	24.5

a. The AROP rate is a relative measure in that it would record the same values if all incomes were doubled or all incomes were halved.
Source: Eurostat

3. National indicators

Minimum guaranteed income*	€ 926,5		1 July 2013	The Netherlands government website
Minimum wage	€ 1.477,8	gross	1 July 2013	The Netherlands government website
Minimum pension**	€ 1.086,5	gross	1 July 2013	Social Insurance Bank (SVB)
Average wage	€ 3.482,7	gross	2013***	CBS Statline
Average pension	NA			

a. Single person, incl. supplement of € 264,7 for those who can't share costs of living.
b. 50 years of residence required for full minimum pension. If this is not the case and people do not have any additional income (from their own build-up of second-pillar pension), in case of a continuous low-income situation and costs cannot be shared, then a supplement can be provided as indicated under a.
c. Latest complete and comparable data available.

4. People below Eurostat 40% and 60% poverty thresholds as % of total population

	2012		2013	
	%	Number	%	Number
<40%	2.4%	401'528	2.5%	425'000
40% to 60%	7.7%	1'288'237	7.8%	1'310'000
Population		16'730'348		16'771'207

Source: Eurostat

5. Income and poverty indicators by type of household

	2012		2013	
	Average net income	AROP (60% threshold)	Average net income	AROP (60% threshold)
Two adults	€ 2.136,8	4,9	€ 2.206,3	5,7
Single person with dependent children	€ 1.352,1	28,2	€ 1.403,8	20,1
Two adults, 1 dependent child	€ 2.061,9	4,0	€ 2.069,4	6,5
Two adults, 2 dependent children	€ 1.943,1	6,8	€ 1.941,3	4,7
Two adults, 3 or more dependent children	€ 1.683,6	16,7	€ 1.665,9	20,1

Source: Eurostat

6. Social benefits in comparison to different poverty levels, amount per month (euros)[a]

Benefits/payments	2013	
Minimum wage	€ 1.477,8	per 1 July 2013
Legal minimum pension	€ 1.086,5	per 1 July 2013
Standard beneficiary pension	€ 1.086,5	per 1 July 2013
Average pension	-	
Survivor benefit	€ 1.120,2	Net gross survivor benefit, per 1 July 2013
Unemployment insurance benefit (UI - 3 months)	€ 1.034,5	per 1 July 2013 (70% of minimum wage)
Maternity insurance benefit	€ 1.477,8	per 1 July 2013 (100% of minimum wage)
Disability Insurance (permanent)	€ 1.108,4	per 1 July 2013 (75% of minimum wage)
GMI (single)	€ 926,5	single person (incl. supplement of € 264,7)
GMI (per adult living in a household)	€ 661,8	single person (excl. supplement of € 264,7)
At-risk-of-poverty threshold, 40 % (AROP)	€ 694,7	
At-risk-of-poverty threshold, 60 % (AROP)	€ 1.042,0	

a. To enable a proper comparison of benefits/payments to the different poverty levels 2013, the amounts in table 6 have been set at the level that was in force on 1 July 2013.
b. In the Technical Note various amounts (as of 1 January or 1 July 2014) are included for which the reference moments are not comparable to the poverty thresholds which applied in 2012.
Source: The Netherlands government website, SVB, Eurostat

2. Additional data on poverty

The most recent data on poverty in the Netherlands stem from the Poverty Survey 2014[19] (the yearly joint report of two independent bureaus, Statistics Netherlands (CBS) and the Netherlands institute for Social Research (SCP). The data used in the Poverty Survey contain figures over 2013 and forecasts for the years 2014 and 2015.

The two bureaus use different thresholds[20] to measure poverty. CBS uses the low-income threshold while SCP employs a budget-approach. Despite their different thresholds, the situation of poverty and the affected groups show similar trends and developments.

The Survey indicates an increase in the Dutch poverty rate once again in 2013 – according to both thresholds. Forecasts indicate that the poverty rate will fall slightly in 2014 and 2015. This suggests that the rise in poverty which stemmed from the onset of the economic crisis at the end of 2008, reached its peak in 2013.

The predominant conclusions of the Survey can be highlighted as follows:

The share of Dutch households and individuals living below the poverty line rose in 2013. This was also the case in 2011 and 2012. Forecasts suggest a slight fall in 2014 and 2015.

- Both the number of households as well as the number of persons living in a household below the low-income threshold increased with 1.0 percentage point compared with 2012.

Long-term poverty also rose in 2013.

- According to both thresholds long-term poverty rose with 0.4 percentage points (from 2.6% to 3.0% and from 2.5% to 2.9%) representing the largest increase in the percentage of households at risk of long term poverty since the onset of the economic crisis.
- More than half of these households were recipients of social assistance benefits.
- Despite this negative development, the percentage of households at risk of long-term poverty is still lower than during the beginning of this century, when it reached above 4%.

The poverty rate is highest among lone-parent families, singles aged up to 65, non-Western households, social assistance benefit-recipients and children. All these groups saw their income position deteriorate further in 2013 compared with 2012.

- In all groups which have traditionally been at high risk of poverty, the share of households with an income below the low-income threshold increased further in 2013.
- Analyzed by principal source of income, households in receipt of social assistance benefit were by far most often forced to live on an income below the low-income threshold in 2013 – 78%, 4 percentage points more than in 2012. They were followed at some distance by households in receipt of disability benefit (30.6%) and unemployment benefit (25.3%). The proportion of low-income households among those not dependent on benefit was highest

[19] For details and tables see the English Summary and Press-release here: http://www.scp.nl/english/Publications/Summaries_by_year/Summaries_2014/Poverty_Survey_2014

[20] SCP discusses poverty on the basis of the modest but adequate criterion.
This is a norm amount based on the minimum necessary expenditure for food, clothing, housing and social participation. SCP measures poverty primarily at the level of individual persons.
CBS describes the risk of poverty on the basis of the low-income threshold. This threshold represents a fixed level of purchasing power and is adjusted annually only on the basis of price changes. CBS describes the risk of poverty primarily at household level.

among the self-employed in 2013 (13.4%); the figure for households where wages were the main source of income was 4.2%.

- For single-parent families the percentage increased from 29% to almost 34%. Single mothers are overrepresented.
- For singles aged up to 65 the figure increased from 20% to over 22%
- For non-Western households the increase was from just under 29% to almost 32%. Non-Western households of the second generation were at substantially lower risk of poverty in 2013 than members of the first generation (23% versus 33%).
- Children are overrepresented in the various at-risk of poverty groups and their number has been rising since 2007. One in three people in poverty are aged under 18; three quarters of children in poverty are aged under 12. Their risk of poverty increases when:
    - Their parents are in receipt of social assistance benefit;
    - their parents are self-employed;
    - they live in a family with three or more children;
    - they live in single-parent families;
    - they have a non-Western background.
- The share of all at-risk groups on a long-term low income also increased more than average in 2013.

Poverty is concentrated in the large cities.

- According to both thresholds the largest share of people in poverty are located in the larger cities, especially in Rotterdam, Amsterdam, The Hague and Groningen. These cities know great disparities though and poverty is predominantly concentrated in specific zip-code areas.

<u>Further highlights</u>

- The poverty rate among the self-employed (13%) is much higher than among people in waged employment (3%).
    - This continuing favorable position of older persons is due mainly to the state old-age pension, which is often sufficient even without a supplementary pension to ensure that recipients do not end up in poverty.
- Poverty among older households has also risen over recent years yet is far below the national average.
- The poverty threshold is based on income, and it is therefore important to ascertain the extent to which people have financial assets. Tenants and social assistance benefit recipients who are below the poverty threshold generally have few assets. Of the 32% of poor people living in an owner-occupied home, more than a quarter are in negative equity, with an outstanding mortgage that is greater than the market value of their home. Nonetheless, there is also a substantial group of poor people who do have assets. Out of the total group, 15% have freely disposable assets of at least 50,000 euros, and 18% have surplus equity in their home of 50,000 euros or more. Most of them are either self-employed or pensioners.

3. The policy priorities of the government in relation to poverty

It is worthwhile to mention that the macro-economic figures and poverty statistics – as provided above - do not include municipal income assistance nor local tax waivers. Neither do these figures do full justice to the endeavor of the government to support local authorities and civil society organizations nor to the effort of all parties to cooperate extensively and integrate services to find sustainable solutions out of poverty.

Social protection has predominantly been decentralized in the Netherlands placing municipalities in the frontline when it comes to a large range of social services and care such as youth-care, community shelter, participation, poverty, social inclusion and debt-relief. Municipalities are not just responsible for the delivering of services, they are for a large part also in charge of the assessment procedure and have – to a great extent – discretion over the type, height or length of services to be provided in a given circumstance. The main reason behind this decentralized form of governance is to encourage tailor-made support for the individual or family in question.

Although these are decentralized tasks, fighting poverty, social exclusion and debt is a priority for this cabinet and the Dutch government has intensified its policies. For instance, additional structural funding has been made available – € 100 million structurally. Most of this is granted to municipalities. But they are not the only parties who contribute to sustainable solutions out of poverty. Therefore the Dutch government has also made extra money available for civil society organizations through a subsidy-scheme to encourage activities that will make a sustainable contribution to combating poverty and debt-related problems.

Three recent reports submitted to the European Commission provide a broad and up-to-date overview of how the Dutch government is investing in an inclusive, participating society. The National Social Report of 2014 describes the most important policy measures and reforms with regard to social inclusion, pensions, health care and long-term care. The National Reform Program of 2015 also singles out the policy measures aimed at increasing labor participation and the realization of an inclusive labor market. The Strategic Social Report of 2015 describes the commitment of the Dutch government and its cooperation with the local public and private stakeholders. The documents are publically available through the site[21] of the European Commission.

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[21] http://ec.europa.eu/social/main.jsp?catId=758