March 2022

EUROPEAN SOCIAL CHARTER (REVISED)

European Committee of Social Rights

Conclusions 2021

NETHERLANDS

This text may be subject to editorial revision.

The function of the European Committee of Social Rights is to rule on the conformity of the situation in States with the European Social Charter. In respect of national reports, it adopts conclusions; in respect of collective complaints, it adopts decisions.

Information on the Charter, statements of interpretation, and general questions from the Committee, is contained in the General Introduction to all Conclusions.

The following chapter concerns the Netherlands, which ratified the Revised European Social Charter on 3 May 2006. The deadline for submitting the 14th report was 31 December 2020 and the Netherlands submitted it on 26 January 2021.

The Committee recalls that the Netherlands was asked to reply to the specific targeted questions posed under various provisions (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter). The Committee therefore focused specifically on these aspects. It also assessed the replies to all findings of non-conformity or deferral in its previous conclusions (Conclusions 2013).

In addition, the Committee recalls that no targeted questions were asked under certain provisions. If the previous conclusion (Conclusions 2013) found the situation to be in conformity, there was no examination of the situation in 2020.

Comments on the 14th report by the Dutch section of the International Commission of Jurists (NJCM) were registered on 1 July 2021. The reply from the Government to these comments was registered on 17 September 2021.

In accordance with the reporting system adopted by the Committee of Ministers at the 1196th meeting of the Ministers' Deputies on 2-3 April 2014, the report concerned the following provisions of the thematic group II "Health, social security and social protection":

- the right to safe and healthy working conditions (Article 3);
- the right to protection of health (Article 11);
- the right to social security (Article 12);
- the right to social and medical assistance (Article 13);
- the right to benefit from social welfare services (Article 14);
- the right of elderly persons to social protection (Article 23);
- the right to protection against poverty and social exclusion (Article 30).

The Netherlands has accepted all provisions from the above-mentioned group.

The reference period was from 1 January 2016 to 31 December 2019.

The conclusions relating to the Netherlands concern 15 situations and are as follows:

– 9 conclusions of conformity: Articles 3§1, 3§3, 11§1, 12§2, 12§3, 13§1, 14§1, 14§2 and 30.

– 2 conclusions of non-conformity: Articles 12§4 and 23.

In respect of the other 4 situations related to Articles 3§2, 11§2, 11§3 and 13§4, the Committee needs further information in order to examine the situation.

The Committee considers that the absence of the information requested amounts to a breach of the reporting obligation entered into by the Netherlands under the Revised Charter.

The next report to be submitted by the Netherlands will be a simplified report dealing with the follow up given to decisions on the merits of collective complaints in which the Committee found a violation.

The deadline for submitting that report was 31 December 2021.

Conclusions and reports are available at www.coe.int/socialcharter.

Article 3 - Right to safe and healthy working conditions

Paragraph 1 - Safety and health regulations

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee notes that for the purposes of this report, States were asked to reply to the specific targeted questions put to them in relation to Article 3§1 of the Charter, as well as, where applicable, previous conclusions of non-conformity or deferrals (see appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the remit of the thematic group "Health, social security and social protection").

In its previous conclusion, pending receipt of the information requested, the Committee concluded that the situation in the Netherlands was in conformity with Article 3§1 of the Charter (Conclusion 2013). The assessment of the Committee will therefore only concern the information provided by the Government in response to the targeted questions.

The Committee wishes to point out that it will take note of the reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e., after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

General objective of the policy

In its targeted question, the Committee asked about policy formulation processes and practical arrangements made to identify new or emerging situations that represent a challenge to the right to safe and healthy working conditions, the results of such processes as well as intended future developments.

In reply to the Committee´s question, the report states that the occupational safety and health policy is guided by the principle that employers and employees share primary responsibility for maintaining a safe and healthy working environment, since they determine the actual working conditions in the workplace. The report also explains that employers have the responsibility to ensure that workplaces comply with occupational safety and health (OSH) standards and to instruct employees and provide them with the necessary work equipment and personal protective equipment (PPE). The employee is obliged to take care of his own safety and health and that of other persons involved in his actions at the workplace, by using the prescribed work equipment and PPE in accordance with his training and the instructions given by the employer. The report also states that the statutory rules in the Netherlands are in line with EU legislation and notes that the Social Affairs and Employment Inspectorate (formerly the Labour Inspectorate) monitors compliance with these rules. The report also establishes that the government supports employers and employees in achieving safe and healthy working conditions by sharing knowledge and developing tools relating to the main occupational risks and measures.

The Committee notes that, according to the report, an extensive monitoring and research programme has been devised to track how working conditions are changing in the Netherlands. It also notes that, every five to eight years, the policy plan is either updated or newly devised. It comments that, according to the report, should there be a change of government during the term of a policy plan, parts of the plan may also be revised. The report explains that general policy priorities, which are fleshed out in a policy programme (annual plan) and a programme for monitoring compliance with legislation, and available funding each year, are set out in the government's budget.

The report states that several factors determine the content of the multiannual and annual policy plans, including periodic consultation between government and parliament on occupational safety and health policy, during which the government renders its account for the policy pursued and the parliamentary parties express their views on this policy and any revisions thereof; opinions of employers' and employees' organisations, as well as of experts and professionals in the field of occupational safety and health; factual information about current working conditions obtained from monitoring studies, including a number of large-scale surveys of employees, employers and self-employed people; findings of monitoring activities, and results of research into occupational risks (for example, on new and emerging hazards).

The report states that the government recently began working on a new multiannual policy plan for the coming years, as it was felt that the policy has stalled in some areas and that the current plan falls short in addressing a number of topical issues such as changes in labour relations, the accelerating development of digital technology, the focus on the efficient deployment of labour, an improved understanding of today's occupational risks, and a new political environment. The report remarks that the policy pursued in recent years is under close scrutiny and that the parliament is establishing the building blocks for a new multiannual policy plan through consultation with employers' and employees' organisations and other relevant stakeholders, all of the which is expected to provide the basis for a broad outline of the policy plan for the years ahead.

The Committee notes that policy plans and strategies in the Netherlands are periodically assessed and reviewed, particularly in the light of changing risks, which should lead to the identification of diseases at earlier stages and promote better recording of occupational diseases.

Organisation of occupational risk prevention

The Committee has previously noted that, at state and company level, there is a system for the assessment of occupational risks, preventive measures geared to the nature of the risks involved, and information and training measures for workers (Conclusions 2013). It also noted that the Labour Inspectorate is involved in developing a health and safety culture among employers and workers, and shares its experience through implementing instructions, prevention measures and consultations.

Improvement of occupational safety and health

The Committee has previously noted that there is a system geared to the improvement of safety and health at work through research, development and training (Conclusions 2013) .

Consultation with employers' and workers' organisations

The Committee has previously noted that the formulation, implementation and periodic review of policy on health and safety at work draws heavily on an effective social dialogue (Conclusions 2013).

COVID-19

In its targeted question, the Committee asked about the protection of frontline workers, instructions and training, the quantity and the adequacy of personal protective equipment provided to workers, and the effectiveness of these measures within the context of the Covid-19 pandemic.

According to the report, specific guidelines such as the Covid-19 guidelines issued by the National Coordination Structure for Infectious Disease Control (LCI) (*Landelijke Coördinatie Infectieziektebestrijding*) have been drafted for healthcare professionals in hospitals and those working outside a hospital setting, such as GPs, district nurses, care workers funded

from the Social Support Act, disability carers, staff in care homes, ambulance crews, staff in assisted-living centres, carers in small-scale residential homes, and mental healthcare workers. The infection prevention expert team of the Netherlands Federation of Medical Specialists (*Federatie Medische Specialisten*) has also drawn up a separate policy on the testing and deployment of healthcare workers in hospitals.

The report also states that the Netherlands Government constantly assessed the situation and in order to provide the adequate PPE and medical devices of the right quality as soon as possible faced the severe shortages of CE-marked PPE and medical devices used by healthcare professionals, such as gloves, face masks and gowns. The Ministry of Health, Welfare and Sport set up the National Consortium for Medical Devices (LCH) (*Landelijk Consortium Hulpmiddelen*) with the aim of procuring sufficient PPE and medical devices of the right quality as fast as possible. In addition, the Ministry of Health, Welfare and Sport commissioned the National Institute for Public Health and the Environment (RIVM) to assess the quality of the goods purchased by the LCH. For this purpose, RIVM set up a multidisciplinary quality team that brings together expertise from within and outside the organisation and whose primary task is to assess the quality of goods purchased by the LCH so that only PPE of sufficient quality is released for use.

In line with its Statement on Covid-19 and social rights (March 2021), the Committee recalls that in the context of the Covid-19 crisis, and with a view to mitigating the adverse impact of the crisis and accelerating the post-pandemic social and economic recovery, each State Party must assess whether its existing legal and policy frameworks are adequate to ensure a Charter-compliant response to the challenges presented by Covid-19. Where those frameworks are not adequate, the State must amend them including through the adoption of any additional measures that are required to ensure that the State is able to comply with its Charter obligations in the face of the social rights risks posed by the Covid-19 crisis. In the same vein, the Committee recalls that the Covid-19 crisis does not obviate the requirements set out by its long-standing jurisprudence regarding the implementation of the Charter and the obligation of the States Parties to take measures that allow them to achieve the objectives of the Charter within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources.

The Committee points out that, in order to secure the rights set out in Article 3, a response to Covid-19 in terms of national law and practice should involve the immediate introduction of health and safety measures at the workplace such as adequate physical distancing, the use of personal protective equipment, strengthened hygiene and disinfection measures, as well as stricter medical supervision, where appropriate. In this respect, due account should be taken of the fact that certain categories of workers, such as frontline health care workers, social workers, teachers, transport and delivery workers, garbage collection workers, and agro-food processing workers are exposed to heightened risks. States Parties must ensure that their national policies on occupational safety and health, and their health and safety regulations, reflect and address the hazardous agents and the particular psychosocial risks faced by different groups of workers in the Covid-19 context. The Committee also stresses that the situation requires a thorough review of occupational risk prevention, at national policy level, as well as at company level, in close consultation with the social partners as stipulated by Article 3§1 of the Charter. The national legal framework may require amendment, and risk assessments at company level must be adapted to the new circumstances.

Conclusion

The Committee concludes that the situation in the Netherlands is in conformity with Article 3§1 of the Charter.

Article 3 - Right to safe and healthy working conditions

Paragraph 2 - Safety and health regulations

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee recalls that for the purposes of the present report, States were asked to reply to targeted questions for Article 3§2 of the Charter as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

The Committee notes that the previous conclusion was of conformity (Conclusions 2013). The assessment of the Committee will therefore only concern the information provided by the Government in response to the targeted question.

Content of the regulations on health and safety at work

The Committee previously found the situation to be in conformity in this respect but requested that the next report updated all relevant legislation and regulations (Conclusions 2013).

In its targeted question on Article 3§2, the Committee asked for information on regulations adopted to improve health and safety in evolving new situations such as in the digital and platform economy by, for example, strictly limiting and regulating electronic monitoring of workers, by recognising a right to disconnect, right to be unavailable outside agreed working and standby time, mandatory digital disconnection from the work environment during rest periods. It also requested information on regulations adopted in response to emerging occupational risks.

The report indicates that under the Act on Working Conditions (No. 184/1999) the employers are required to implement policies aimed at preventing or reducing work-related stress. The number of burnout cases was increasing in recent years and the Government has started a research into the underlying causes of burnout in relation to work-life balance. In December 2019 a report was published on burnout causes and growing number of cases. The report states that further research was to be carried out in 2020. Currently, the Government focuses on making the work of confidential advisers more professional and providing information about it. Confidential advisers can be used by employers to prevent or reduce work-related stress. The report also indicates that employers can draw up a code of conduct in order to create a safe and supportive working environment and discourage inappropriate behaviour in the workplace.

The Committee points out that the information requested in response to the targeted question is insufficient. The Committee therefore repeats its request for information. The Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the situation in the Netherlands is in conformity with Article 3§2 of the Charter on this point.

The Covid-19 pandemic has changed the way many people work, and many workers now telework or work remotely. Teleworking or remote working may lead to excessive working hours.

The Committee considers that, consistent with States Parties' obligations in terms of Article 3§2, in order to protect the physical and mental health of persons teleworking or working remotely and to ensure the right of every worker to a safe and healthy working environment, it is necessary to enable fully the right of workers to refuse to perform work outside their normal working hours (other than work considered to be overtime and fully recognised

accordingly) or while on holiday or on other forms of leave (sometimes referred to as the "right to disconnect").

States Parties should ensure there is a legal right not to be penalised or discriminated against for refusing to undertake work outside normal working hours. States must also ensure that there is a legal right to protection from victimisation for complaining when an employer expressly or implicitly requires work to be carried out outside working hours. States Parties must ensure that employers have a duty to put in place arrangements to limit or discourage unaccounted for out-of-hours work, especially for categories of workers who may feel pressed to overperform (e.g. those during probationary periods or for those on temporary or precarious contracts).

Being connected outside normal working hours also increases the risk of electronic monitoring of workers during such periods, which is facilitated by technical devices and software. This can further blur the boundaries between work and private life and may have implications for the physical and mental health of workers.

Therefore, the Committee considers that States Parties must take measures to limit and regulate the electronic monitoring of workers.

Establishment, alteration and upkeep of workplaces

In its previous conclusion, the Committee noted that no measures had been taken to transpose Directive 2009/104/EC of the Parliament and of the Council of 16 September 2009 concerning the minimum safety and health regulations for the use of work equipment by workers at work. The Committee also asked for information on measures taken at the national level or agreed by the social partners for the establishment, alteration and upkeep of workplaces, as well as for indication of the international or European standards which the legislation and regulations issued or amended during the reference period were designed to incorporate (Conclusions 2013).

The report provides no information requested. According to another source, requirements on workplaces are listed in the *Arbeidsomstandigheden*. According to a further source, no measures have been taken to transpose Directive 2009/104/EC of the Parliament and of the Council of 16 September 2009 concerning the minimum safety and health regulations for the use of work equipment by workers at work.

The Committee takes note of this information.

Protection against hazardous substances and agents

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Personal scope of the regulations

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Consultation with employers' and workers' organisations

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Conclusion

Pending receipt of the requested information, the Committee defers its conclusion.

Article 3 - Right to safe and healthy working conditions

Paragraph 3 - Enforcement of safety and health regulations

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee recalls that for the purposes of the present report States were asked to reply to targeted questions for Article 3§3 of the Charter as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

The Committee deferred its previous conclusion pending receipt of the information requested (Conclusions 2013).

Assessment of the Committee will therefore concern the information provided by the Government in response to the deferral and to the targeted questions.

Accidents at work and occupational diseases

The Committee previously examined the situation regarding accidents at work and occupational diseases and deferred its conclusions pending receipt of the information requested, concerning steps taken to remedy the high overall level of accidents at work; the incidence rate for cases of occupational diseases; steps taken to remedy the increase in the number of occupational diseases (Conclusions 2013). In its targeted question on Article 3§3 with regard to accidents at work and occupational diseases, the Committee asked for information on statistical data on prevalence of work-related death, injury and disability including as regards suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders, as well as on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs (e.g. cycle delivery services, including those employed or whose work is managed through digital platform; performers in the sports entertainment industry, including in particular contact sports; jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive products; new forms of high-yield high-stress trading; military and law enforcement; etc.) and also as regards the victims of harassment at work and poor management.

In reply, the report explains that statistics on the prevalence of work-related death, injury and invalidity in the Netherlands are based on various sources. Workplace accidents are recorded by the Social Affairs and Employment (SZW) Inspectorate. The report also explains that the data on the incidence of occupational illness or disease is a rough estimate, as no actual figures are available. In addition to the notifications received by the Netherlands Centre for Occupational Diseases (*Nederlands Centrum voor Beroepsziekten,* NCvB), data is also obtained from the periodic Netherlands Working Conditions Survey (*Nederlandse Enquête Arbeidsomstandigheden, NEA*), a large-scale survey of more than 40,000 employees who give their opinion on their working conditions and can report whether they have an illness or disease caused by their work. This self-reported data differs considerably from the notifications made to the NCvB.

According to the report, in 2005 and 2010 two studies were carried out into work-related death in the Netherlands, the main findings of which were that workplace accidents account for only a fraction of work-related deaths. In particular, death due to exposure to carcinogens is a highly underestimated risk. Partly in response to these two studies, the SZW Inspectorate has now stepped up its enforcement of hazardous substance regulations. The studies also prompted the Ministry of Social Affairs and Employment to request further research from the National Institute for Public Health and the Environment (RIVM), which

now regularly updates the figures. The RIVM data is based on epidemiological research rather than on actually diagnosed cases. The figures provided by the report show exposure to hazardous substances to be by far the most common cause of premature death, predominantly occurring after retirement (a key reason why employers are not aware of the problem). RIVM estimates the number of premature deaths due to exposure to carcinogens at more than 2,500 per year and reports 750 deaths due to cardiovascular diseases and 700 deaths due to respiratory disease caused by workplace exposure to hazardous substances.

The report states that the number of fatal workplace accidents reported in the Netherlands has been below 50 per year since 2009. In 2017 and 2018, this figure is slightly higher than 40. According to EUROSTAT data, the standardised incidence rate of fatal accidents at work in the Netherlands was 0.78 in 2017 and 0.87 in 2018. These figures are significantly below the average rates of such accidents in the EU-27 (2.25 in 2017 and 2.21 in 2018).

The report indicates that the number of non-fatal "serious" occupational accidents slightly increased during the reference period (4,500 in 2019 and 4,300 in 2018). According to EUROSTAT data, the number of non-fatal accidents causing four calendar days of absence in the Netherlands was 64,238 in 2019, 63,777 in 2018 and 64,872 in 2017. The incidence rate of such accidents was 1,431.88 in 2018 and 1,451.65 in 2017. These figures are lower than the EU-27 average (1,768.93 in 2018 and 1,800.96 in 2017). According to the report, the increase in notifications of workplace accidents can have several causes. In any case the high, sustained economic activity and employment growth over the reporting period plays a part. As a result, the number of flexible workers (who are involved in workplace accidents relatively often) is rising. Another explanation for the upward trend is the fact that fines for failing to report workplace accidents have increased.

As to occupational diseases, the report explains that company doctors in the Netherlands are required to report occupational illnesses to the NCvB. These 'official' notifications amount approximately to 4,000 a year. One way to ascertain the incidence of occupational illness is the Netherlands Working Conditions Survey (NEA), which provides self-reported data on whether respondents attribute their symptoms wholly or partly to their work and have had their symptoms medically diagnosed. In 2018, the number of occupational illnesses notified to the NCvB was 3,854 (concerning physical stress -1.6% of cases-, work-related stress -1.5%-, hazardous substances -0.2%-).

According to the report, work-related stress is one of the priorities of the SZW Inspectorate and has its own dedicated programme (Work-related stress/Employment discrimination). This is mainly due to the fact that mental health problems are the most reported type of occupational illness and the number of employees reporting such problems continues to rise every year. The main categories of work-related mental health problems are burnout and post-traumatic stress disorder (PTSD). Of the occupational illnesses reported to the NCvB in the 'mental health' category, emotional exhaustion and burnout and post-traumatic stress disorder (PTSD) appear to be the largest diagnostic category by far. According to the report, the number of cases reported to the NCvB concerning emotional exhaustion and burnout was 1,664 in 2019 (74.9% of all cases under mental health category) and concerning post-traumatic stress disorder, was 298 (13.4% of all cases under mental health category).

Concerning inappropriate behaviour at work and poor management, since 2011 the Netherlands Working Conditions Survey has also included questions on inappropriate behaviour, by both external parties (customers, patients, pupils, passengers) and internal parties (managers, colleagues). The report indicates that according to the Working Conditions Survey broadly speaking, a quarter of all Dutch employees are subjected to inappropriate behaviour by external parties at least once a year (28.9% of the total number of employees), and one in six by colleagues (19.3% of the total number of employees).

The Committee requests that the next report provide detailed and updated information concerning steps taken to remedy the increase in the number of occupational diseases concerning in particular work-related mental health. It also requests updated and detailed

information on measures taken in order to remedy the increase in the number of fatalities for exposure to carcinogens and cardiovascular diseases.

Activities of the Labour Inspectorate

In the previous conclusion, the Committee reiterated its request for information on the number of workers covered by inspection visits in relation to the labour force (Conclusions 2013). It also asked that the report provide updated information on the specialised inspectorates, especially on the competence divide between the inspectorates in matters of occupational health and safety. Given the decline in staffing, in the number of inspection visits and in the number of accident investigations, it further asked for information on steps taken to remedy lower compliance with the law, the increase in complaints and the increase in situations requiring work suspensions.The targeted questions with regard to the activities of the Labour Inspectorate concerns the organisation of the Labour Inspectorate, and the trends in resources allocated to labour inspection services, including human resources; number of health and safety inspection visits by the Labour Inspectorate and the proportion of workers and companies covered by the inspections as well as the number of breaches to health and safety regulations and the nature and type of sanctions; whether inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors.

The SZW Inspectorate seeks to ensure that everyone enjoys fair, safe and healthy working conditions and socio-economic security. Supervision and investigation are the tools used in situations where the most persistent problems arise, and the effect is greatest. The Inspectorate takes a risk-based, programme-driven approach based on risk analyses and environmental analyses. Organisational restructuring began on 1 July 2017 in order to transform the Inspectorate into a modern and agile organisation with a programme and project-based way of working to ensure maximum flexibility. Furthermore, prompted by the coalition agreement 'Confidence in the Future', additional funding was provided for the Inspectorate at the end of 2017. The expenditure of the Labour Inspectorate in 2016 was 103 million € and 131 million € in 2019. A large part of these extra resources is being used to expand its workforce. As a result, the number of inspectors increased from 1,149 in 2016 to 1,355 in 2019. The report indicates that this number will be 1,550 by the end of 2022 (outside the reference period).

As to the number of health and safety inspection visits by the Labour Inspectorate and the proportion of workers and companies covered, the report indicates that, in principle, the SZW Inspectorate supervises all establishments in the Netherlands, including institutions such as prisons, police stations and schools, and also monitors compliance with the rules that have also been declared applicable to the self-employed and people working from home. There are almost 1.9 million establishments in the Netherlands, of which more than 1.25 million are self-employed persons without employees and 200,000 which have only one employee. There are therefore over 400,000 establishments with more than one employee. In total, the Inspectorate monitors labour standards for a total of more than 7.3 million employees, as well as for over 1 million self-employed and 30,000 family workers.

Between 2016 and 2018 the number of inspections fell from 16,000 to 8,232, rising again to 9,100 between 2018 and 2019. In order to restore the balance between the capacity required to conduct accident investigations and that required to carry out proactive -more preventive- inspections, it was decided in the 2017 coalition agreement to expand capacity. The rise in the proportion of reactive inspections in the total number of health and safety inspections was halted in 2019 as a result of greater capacity being made available for preventive inspections.

Concerning the number of breaches of health and safety regulations and the nature and type of sanctions, the report underlines that in 2019, enforcement measures were imposed on 46% of establishments where a health and safety inspection was carried out for the first time. Nearly all breaches of health and safety legislation can be sanctioned under

administrative law. The SZW Inspectorate always confirms in writing the sanctions to be imposed, the remedial measures to be taken and the timescale within which the breach or breaches must be rectified. It carries out spot checks to determine whether the required measures have been implemented and, if this is not the case, applies a tougher sanction. In addition to enforcement under administrative law, some breaches of health and safety legislation can be prosecuted under criminal law. Most of the inspectors of the SZW Inspectorate who have supervisory authority also have the role of special enforcement officer (BOA), which authorises them to investigate breaches that are punishable under criminal law and to draw up an official report for the Public Prosecution Service. In the case of fatal accidents, the public prosecutor is always consulted to determine whether a criminal investigation should be launched. If the Public Prosecution Service decides not to initiate criminal proceedings, the public prosecutor informs the inspector so that the latter can decide whether the case should be dealt with under administrative law.

In reply to the targeted question on whether inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors, the report explains that the SZW Inspectorate is entitled to inspect all workplaces. Special rules apply to inspectors entering residential premises. With regard to supervision of the health and safety of employees in a domestic setting, Working Conditions Act stipulates that the supervisory authority is authorised to enter a dwelling without the occupant's permission. However, the inspector in question does need written authorisation to do so. The public prosecutor who has the power to grant authorisation will only do so if the purpose for which it is to be granted reasonably requires entry without the occupant's permission. Written authorisation is not required if immediate entry into the dwelling is necessary in order to prevent or remove a serious and imminent threat to the safety of people or property.

The Committee takes note of the information provided. It asks that the next report provide detailed information on different administrative measures that labour inspectors are entitled to take, the number of such measures actually taken, and the number and outcome of cases referred to the prosecution authorities with a view to initiating criminal proceedings; and figures for each year of the reference period.

Conclusion

The Committee concludes that the situation in the Netherlands is in conformity with Article 3§3 of the Charter.

Article 3 - Right to safe and healthy working conditions

Paragraph 4 - Occupational health services

The Committee notes that no targeted questions were asked under Article 3§4 of the Charter. As the previous conclusion found the situation in the Netherlands to be in conformity with the Charter, there was no examination of the situation in 2021.

Article 11 - Right to protection of health

Paragraph 1 - Removal of the causes of ill-health

The Committee takes note of the information contained in the report submitted by the Netherlands. It also takes note of the comments of the Netherlands Trade Union Confederation (FNV) which are included in the national report. It further takes note of the comments submitted by the Dutch section of the International Commission of Jurists (NJCM) on 1 July 2021 and of the Government's reply to these comments submitted on 17 September 2021.

The Committee recalls that for the purposes of the present report, States were asked to reply to targeted questions for Article 11§1 of the Charter, as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

In its previous conclusion, the Committee concluded that the situation in the Netherlands was in conformity with Article 11§1 of the Charter (Conclusions 2013). The assessment of the Committee will therefore only concern the information provided by the Government in response to the targeted questions.

The Committee wishes to point out that it will take note of the reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

Measures to ensure the highest possible standard of health

In a targeted question for this cycle, the Committee asked for overall and disaggregated statistical data on life expectancy across the country and different population groups (urban; rural; distinct ethnic groups and minorities; longer term homeless or unemployed; etc.) identifying anomalous situation (e.g. particular areas in the community; specific professions or jobs; proximity to active or decommissioned industrial or highly contaminated sites or mines; etc.) and on prevalence of particular diseases among relevant groups (e.g. cancer) or blood borne infectious diseases (e.g. new cases HIV or Hepatitis C among people suffering from substance use disorders or who are held in prison; etc.).

The report provides statistics with regard to life expectancy for women and men. In 2018, the overall life expectancy for women was 3.1 years higher than for men (83.3 vs 80.2), but women can expect to enjoy fewer life years in good health than men. The report indicates that disability-free life expectancy was lower for women than for men in 2018. For example, the difference was 4.6 years in terms of self-perceived good health, 5.4 years without disabilities, 10.2 years without chronic diseases and 4.2 years without good mental health. The report further states that in 2018, life expectancy without chronic diseases was 7.1 years higher for men than for women (47.3 vs 40.2 years), whereas with chronic diseases it was 10.2 years higher for women than for men (43.1 years vs 32.9 years). Women therefore spend many more years living with chronic diseases than men do. Almost three quarters of the large difference in life expectancy at birth (10.3 years) between men and women with chronic diseases is due to the onset of a chronic disease before the age of 65.

The report further indicates that based on purely demographic trends, the absolute number of people with dementia, heart failure or Parkinson's disease will increase by 60% or more in the period 2015-2040. As these conditions occur mainly in older persons, population ageing leads to an increase in the absolute number of people with these diseases. Conversely, health problems that are less common in the older persons, such as work-related accident

injuries, emotional exhaustion and burnout, are decreasing due to demographic trends (ageing). The increase or decrease may be lower or higher due to changes in factors that affect the risk of developing a particular health issue (epidemiological developments).

The Committee takes note of the information provided in the report with respect to gender differences in life expectancy for women and men, and trends with regard to the older persons. However, it reiterates its request for information on overall and disaggregated statistical data on life expectancy across the country and different population groups (urban; rural; distinct ethnic groups and minorities; longer term homeless or unemployed; etc.) identifying anomalous situation (e.g. particular areas in the community; specific professions or jobs; proximity to active or decommissioned industrial or highly contaminated sites or mines; etc.) and on prevalence of particular diseases among relevant groups.

The Committee notes that according to the comments submitted by the the Dutch section of the International Commission of Jurists, the life expectancy in rural areas, in particular in the so-called “krimp-regions” is somewhat lower than elsewhere in the Netherlands. The same comments indicate that in the “krimp-regions” there are more people with high blood pressure or obesity, more people smoke, and more people are at risk of depression or anxiety disorders. The NJCM also raises concerns related to the accessibility of health services in rural areas, namely the lack of health professionals and facilities, the fact that the available facilities and professionals are difficult to access physically, and the growing costs for healthcare in the “krimp-regions” as well as the budgetary problems experienced by municipalities in these areas.

In its reply to the comments of NJCM, the Government highlights that municipalities are responsible for providing social assistance for persons in need in accordance with the Act on social assistance of 2015. This act gives municipalities a substantive amount of flexibility to create policies suitable to the local situation, also in rural regions. The Government states that the act guarantees that persons with a disability are entitled to appropriate assistance. It further states that financial shortfalls within a municipal budget do not constitute grounds for denying care.

The Committee asks that the next report provide information on measures taken to address any existing gaps between rural and urban regions in the provision of healthcare.

Access to healthcare

In reply to the Committee’s targeted question on information on sexual and reproductive healthcare services for women and girls (including access to abortion services), the report indicates that the Netherlands is committed to girls’ and women’s sexual and reproductive health and rights. Sexual healthcare is freely available from general practitioners (GPs). The costs are covered by health insurance with a personal contribution. In addition to regular access to sexual healthcare for specific target groups (such as young people under 23 years and sex workers), it is also available, anonymously and free of charge, at regional sexual health clinics. The report adds that during the first few months of the Covid-19 epidemic (outside the reference period), access to sexual healthcare via these regional clinics was very restricted due to the fact that the regional health sector focused its efforts on fighting the epidemic; however, in the meantime, access to these services has resumed.

The report indicates that there are 15 abortion clinics in the Netherlands. Abortion care is available unconditionally and free of charge for women living in the Netherlands, without a referral from a GP. Abortion clinics also provide information about contraception and the prevention of unplanned pregnancy. Birth control, and specifically the birth control pill, are important factors in preventing unplanned pregnancies. The birth control pill is prescribed by a GP and the cost is covered by health insurance with a personal contribution. The report further provides statistical information on abortions – from a total of 31,002 abortions carried out in 2018, 27,620 of them concerned women living in the Netherlands and 2,520 of the

abortions carried out related to teenage pregnancy, 49 of which involving girls under the age of 15.

The Committee takes note of the comment of the Netherlands Trade Union Confederation (FNV) stating that the personal contribution for reproductive products is a barrier for girls and women to the purchase of contraceptives. According to FNV, contraception should be excluded from personal contributions or "*eigen risico*" (own risk) . The Committee invites the Government to comment on the above-mentioned statement. The Committee further asks for information on the proportion of the cost of contraceptives that is not covered by the State (in cases where the cost is not fully reimbursed by the State).

The report also provides statistical information on early motherhood indicating a downward trend (a total of 1,779 teenage mothers on 1 January 2019 as compared to 1,984 in 2018). The number of children born to mothers under the age of 20 has also fallen. In 2018, 1,310 children were born to teenage mothers, compared with 1,410 a year earlier. The number of teenage mothers decreased significantly between 2010 and 2018, falling by almost 1,500.

The Committee notes that according to Eurostat, the infant mortality rate was 3.6 deaths per 1,000 live births in 2019 (compared to 3.3 in 2015) while the EU average was 3.4 in 2019. The Committee observes the increasing trend in the rate of infant mortality during the reference period and asks for information on the measures taken to reduce it.

The rate of maternal mortality decreased from 6 deaths per 100,000 live births in 2015 to 5 deaths per 100,000 live births in 2017 (the EU average in 2017 was 6 per 100,000 live births) according to World Bank data.

The Committee refers to its general question as regards the right to protection of health of transgender persons in the general introduction. The Committee recalls that respect for physical and psychological integrity is an integral part of the right to the protection of health guaranteed by Article 11. Article 11 imposes a range of positive and negative obligations, including the obligation of the state to refrain from interfering directly or indirectly with the enjoyment of the right to health. Any kind of unnecessary medical treatment can be considered as contrary to Article 11, if accessing another right is contingent upon undergoing that treatment (Transgender Europe and ILGA Europe v. Czech Republic, Complaint No. 117/2015, decision on the merits of 15 May 2018, §§74, 79, 80).

The Committee recalls that state recognition of a person's gender identity is itself a right recognised by international human rights law, including in the jurisprudence of the European Court of Human Rights, and is important to guaranteeing the full enjoyment of all human rights. It also recalls that any medical treatment without free informed consent (subject to strict exceptions) cannot be compatible with physical integrity or with the right to protection of health. Guaranteeing free consent is fundamental to the enjoyment of the right to health, and is integral to autonomy and human dignity and the obligation to protect the right to health (Transgender Europe and ILGA Europe v. Czech Republic, op. cit., §§78 and 82).

The Committee invites states to provide information on the access of transgender persons to gender reassignment treatment (both in terms of availability and accessibility). It asks whether legal gender recognition for transgender persons requires (in law or in practice) that they undergo sterilisation or any other medical requirements which could impair their health or physical and psychological integrity. The Committee also invites states to provide information on measures taken to ensure that access to healthcare in general, including sexual and reproductive healthcare, is provided without discrimination on the basis of gender identity.

In a targeted question, the Committee asked for information on measures to ensure informed consent to health-related interventions or treatment (under Article 11§2). The report indicates that the legal guarantee that people receive sufficient information before consenting to health-related interventions or treatment is enshrined in the Medical Treatment Contracts Act. The Committee notes that since 1 January 2020 (outside the reference

period) this statutory right has been supplemented by several safeguards to facilitate proper consultation between healthcare professionals and patients about the various treatment options available, including those offered by other healthcare providers. As a result, according to the report, patients are better able to have a real exchange of views with healthcare professionals and jointly decide on a particular course of treatment.

Covid-19

In the context of the Covid-19 crisis, the Committee asked the States Parties to evaluate the adequacy of measures taken to limit the spread of virus in the population as well as the measures taken to treat the ill (under Article 11§3).

For the purposes of Article 11§1, the Committee considers information focused on measures taken to treat the ill (sufficient number of hospital beds, including intensive care units and equipment, and rapid deployment of sufficient numbers of medical personnel).

With regard to treating those who are ill, the report indicates that the Netherlands has put in place several measures to ensure that sufficient medical devices, medical personnel, hospital capacity and PPE ("personal protective equipment") are available. At the start of the pandemic, the Netherlands set up a national centre for acquiring medical devices and distributing them evenly across the country. To ensure sufficient medical personnel, hospitals can make use of temporary staff who can apply or volunteer online. The Netherlands is also exploring the possibility of setting up a flexible team of healthcare workers who can be deployed when needed. Lastly, a large-scale public campaign has been launched to attract additional healthcare workers. The report also provides information on the capacity of intensive care units in 2020. It indicates that a full evaluation of the effectiveness of these measures is planned in the near future.

The Committee recalls that during a pandemic, States Parties must take all necessary measures to treat those who fall ill, including ensuring the availability of a sufficient number of hospital beds, intensive care units and equipment. All possible measures must be taken to ensure that an adequate number of healthcare professionals are deployed (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

The Committee recalls that access to healthcare must be ensured to everyone without discrimination. This implies that healthcare in a pandemic must be effective and affordable to everyone, and States must ensure that groups at particularly high risk, such as homeless persons, persons living in poverty, older persons, persons with disabilities, persons living in institutions, persons detained in prisons, and persons with an irregular migration status are adequately protected by the healthcare measures put in place. Moreover, States must take specific, targeted measures to ensure enjoyment of the right to protection of health of those whose work (whether formal or informal) places them at particular risk of infection (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

During a pandemic, States must take all possible measures as referred to above in the shortest possible time, with the maximum use of financial, technical and human resources, and by all appropriate means both national and international in character, including international assistance and cooperation (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in the Netherlands is in conformity with Article 11§1 of the Charter.

Article 11 - Right to protection of health

Paragraph 2 - Advisory and educational facilities

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter with respect to the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

In its previous conclusion, the Committee found that the situation in the Netherlands was in conformity with Article 11§2 of the Charter (Conclusions 2013).

Education and awareness raising

In its targeted questions, the Committee asked for information about health education (including sexual and reproductive health education) and related prevention strategies (including through empowerment that can serve as a factor in addressing self-harm conducts, eating disorders, alcohol and drug use) in the community, on a lifelong or ongoing basis, and in schools.

As regards sexual and reproductive health education, the report indicates that some new initiatives have been launched in order to reduce the number of unwanted and unplanned pregnancies, such as support for comprehensive sexual education adapted to different types of secondary education. In addition, a multimedia campaign on the conscious, responsible use of contraceptives and the consequences of unplanned or unwanted pregnancies is planned to start. The Committee takes note of other measures on unwanted pregnancies undertaken in 2020 (outside the reference period) and will examine them in the next cycle.

With regard to health education in schools, the report states that 'attainment targets' are applicable in primary and secondary education and indicate what schools should include in their curriculum. However, schools are free to determine how these targets are implemented. According to the report, the attainment targets in relation to sexuality and sexual diversity currently cover "learning to respect sexuality and diversity within society, including sexual diversity". The most common teaching methods also consider sexually inappropriate behaviours, such as unwanted sexting. In addition, the report indicates that the attainment targets are shortly due to be reviewed in order to provide schools and teachers with a clearer framework with which education on sexuality, sexual resilience and sexual and gender diversity must comply. The Committee asks that information be provided in the next report on the developments on this matter.

Furthermore, the report indicates that sexuality issues are also addressed in teacher training. The syllabus of both primary school and grade-two teacher training courses was updated to include sexual and gender diversity. In addition, the School & Safety Foundation *(Stichting School en Veiligheid)* with support from the Ministry of Education, Culture and Science, has developed materials that can be used for further education and teacher training, including at universities and other higher education institutions.

The Committee asks that more detailed information be provided in the next report about health education and related prevention strategies (including through empowerment that can serve as a factor in addressing self-harm conducts, eating disorders, alcohol and drug use) in the community, on a lifelong or ongoing basis.

In its targeted questions, the Committee also asked for information about awareness-raising and education with respect to sexual orientation and gender identity (SOGI) and to gender-

based violence. The report does not contain any information on awareness-raising and education with respect to gender-based violence. Therefore, the Committee reiterates its question. It points out that, should the necessary information not be provided in the next report, nothing will enable the Committee to establish that the situation in the Netherlands is in conformity with Article 11§2 of the Charter in this respect.

Counselling and screening

In its previous conclusion, the Committee found that the situation in the Netherlands was in conformity with Article 11§2 with respect to counselling and screening services available for pregnant women and children (Conclusions 2013).

Conclusion

Pending receipt of the information requested, the Committee defers its conclusion.

Article 11 - Right to protection of health

Paragraph 3 - Prevention of diseases and accidents

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about healthcare services in prison; community-based mental health services; drug abuse prevention and harm reduction; healthy environment; immunisation and epidemiological monitoring; Covid-19; and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (namely, after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

In its previous conclusion, the Committee concluded that the situation in the Netherlands was in conformity with Article 11§3 of the Charter (Conclusions 2013).

Healthcare services in places of detention

In a targeted question, the Committee asked for a general overview of healthcare services in places of detention, in particular prisons (under whose responsibility they operate/which ministry they report to, staffing levels and other resources, practical arrangements, medical screening on arrival, access to specialist care, prevention of communicable diseases, mental health-care provision, conditions of care in community-based establishments when necessary, etc.).

The report provides information about the organisation of medical services in prisons, the staffing levels, methodological guidance, initial screening, and prevention of infectious diseases. Inmates have access to in-house medical services or may be referred to external services for specialist treatment. The Custodial Institutional Agency provides a package of services that is aligned with the basic package of services defined in the Health Insurance Act. Each prison has a psychiatrist and a psychologist, whereas inmates may also receive care geared towards stabilisation, recovery, and reintegration in a custodial psychiatric centre, under the supervision of a multidisciplinary team. Inmates with mental disorders may also be referred to mental healthcare settings outside the custodial system.

Community-based mental health services

In a targeted question, the Committee asked for information regarding the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. The Committee also asked for statistical information on outreach measures in connection with the mental health assessment of vulnerable populations and on proactive measures adopted to ensure that persons in need of mental healthcare are not neglected.

Consistent with the World Health Organisation (WHO) Comprehensive Mental Health Action Plan 2013-2030, and other relevant standards, the Committee considers that a human rights-compliant approach to mental health requires at a minimum the following elements: a)

developing human rights-compliant mental health governance through, inter alia, mental health legislation and strategies that are in line with the Convention on the Rights of Persons with Disabilities and other relevant instruments, best practice and evidence; b) providing mental health in primary care community-based settings, including by replacing long-stay psychiatric hospitals with community-based non-specialised health settings; and c) implementing strategies for promotion and prevention in mental health, including campaigns to reduce stigmatisation, discrimination and human rights violations.

The Committee notes that the information requested is not provided. Therefore, the Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the situation in the Netherlands is in conformity with Article 11§3 of the Charter.

Drug abuse prevention and harm reduction

In a targeted question, the Committee asked for information about drug-related deaths and transmission of infectious diseases among people who use or inject psychoactive substances both in the community and in custodial settings. The Committee also asked for an overview of the national policy designed to respond to substance use and related disorders (dissuasion, education, and public health-based harm reduction approaches, including use or availability of WHO listed essential medicines for opioid agonist treatment) while ensuring that the "available, accessible, acceptable and sufficient quality" criteria (WHO's 3AQ) are respected, subject always to the exigency of informed consent. This rules out, on the one hand, consent by constraint (such as in the case of acceptance of detox and other mandatory treatment in lieu of deprivation of liberty as punishment) and, on the other hand, consent based on insufficient, inaccurate or misleading information (i.e. not based on state of the art scientific evidence).

The Committee notes that the information requested is not provided. Therefore, the Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the situation in the Netherlands is in conformity with Article 11§3 of the Charter.

Healthy environment

In a targeted question, the Committee asked for information on the measures taken to prevent exposure to air, water or other forms of environmental pollution, including proximity to active or decommissioned (but not properly isolated or decontaminated) industrial sites with contaminant or toxic emissions, leakages or outflows, including slow releases or transfers to the neighbouring environment, nuclear sites, mines, as well as on the measures taken to address the health problems of the populations affected, and to inform the public, including pupils and students, about general and local environmental problems.

The Committee notes that the information requested is not provided. Therefore, the Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the situation in the Netherlands is in conformity with Article 11§3 of the Charter.

Immunisation and epidemiological monitoring

In a targeted question, the Committee asked States Parties to describe the measures taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.

The report provides information about the various institutional stakeholders tasked with vaccine research, procurement, and fostering public-private partnerships.

Covid-19

The Committee asked States Parties to evaluate the adequacy of measures taken to limit the spread of the Covid-19 virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.).

The report briefly sets out the preventive measures taken to limit the spread of the Coivd-19 virus, including testing, procuring personal protective equipment (PPE), imposing mandates on self-isolation, physical distancing, wearing masks and working from home, and effective public communication.

Conclusion

Pending receipt of the information requested, the Committee defers its conclusion.

Article 12 - Right to social security

Paragraph 1 - Existence of a social security system

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in 2021.

Article 12 - Right to social security

Paragraph 2 - Maintenance of a social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee recalls that the Netherlands ratified the European Code of Social Security and its Protocol on 16 March 1967 and accepted all Parts of the Code. However, it denounced Part VI (employment injury benefit) on 17 March 2008.

The Committee notes from Resolution CM/ResCSS(2020)12 of the Committee of Ministers on the application of the European Code of Social Security and its Protocol by the Netherlands (period from 1 July 2018 to 30 June 2019) that the law and practice in the Netherlands give full effect to all accepted Parts of the Code and the Protocol, except Part IV (unemployment benefit).

The Committee recalls that, to comply with Article 12§2 of the Charter, the social security system of States Parties must cover at least six of Parts II to X of the European Code of Social Security (with Part II, Medical care, counting as two and Part V, Old-age benefit, as three parts). In this respect, the Committee notes that, despite non-compliance with Part IV, the law and practice in the Netherlands give full effect to more than six parts of the Code.

Conclusion

The Committee concludes that the situation in the Netherlands is in conformity with Article 12§2 of the Charter.

Article 12 - Right to social security

Paragraph 3 - Development of the social security system

The Committee takes note of the information contained in the report submitted by the Netherlands and the comments by the Netherlands' Trade Union Confederation (FNV) which are also included in it.

The Committee recalls that States were asked to reply to two targeted questions for Article 12§3 of the Charter as well as, where applicable, the previous conclusions of non-conformity or deferral (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

In its previous conclusion, the Committee found that the situation in the Netherlands was in conformity with Article 12§3 of the Charter (Conclusions 2013). It will therefore restrict its consideration to the Government's replies to the two targeted questions, namely:

- social security coverage, and its modalities, provided to persons employed by digital platforms or whose work is managed via such platforms; and
- any impact of the Covid-19 crisis on social security coverage, and any specific measures taken to compensate for or alleviate any possible negative impact.

The Committee wishes to point out that it will take note of the reply to the second question for information purposes only, as it relates to developments that occurred outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

Platform workers

The Committee recalls that it has posed a targeted question to all States on social security cover for persons employed or whose work is managed by digital platforms. The emergence of these new forms of employment has had a negative impact on certain rights of these workers, as explained in the General Introduction. In matters of social security, compliance with Article 12§3 of the Charter requires that the existing social security systems be adapted to the specific situation and needs of the workers concerned, in order to guarantee that they enjoy the social benefits included within the scope of Article 12§1. The Committee is keenly aware that there are significant gaps in the social coverage of workers in new forms of employment such as platform workers. It considers that the States Parties are under an obligation to take all the necessary measures to address these shortcomings.

In particular States Parties must take steps to ensure that all workers in new forms of employment have an appropriate legal status (employee, self-employed or other category) and that this status is in line with the actual situation thus avoiding abuse (such as the use of "bogus" or "false" self-employed status to circumvent the applicable social security regulations) and conferring adequate social security rights as guaranteed by Article 12 of the Charter on the platform workers.

In its report, the Government states that the social security coverage of persons who are employed via digital platforms depends on the type of contract for the work. If they work for a digital platform on an employment contract, they are covered by national insurance in the event of unemployment (Unemployment Insurance Act), illness (Sickness Benefits Act) and disability (Work and Income Act). If they are self-employed, they are not automatically insured against unemployment, sickness and incapacity for work, and must take out private insurance to cover these risks. If necessary, they can claim social assistance benefits, i.e. a minimum income allowance, subject to certain conditions (Participation Act). The Government also gives details of the eligibility criteria and the levels of unemployment, sickness and incapacity benefits for employees.

Other sources indicate that the Dutch authorities have been taking an interest in the gig or platform economy for some time. For example, a study on “The Rise and the Growth of the Gig Economy in the Netherlands” was commissioned by the Ministry of Social Affairs and Employment and published in January 2018. Focusing on physical labour that is mediated and organised via a platform (e.g. food delivery, passenger transportation, professional and domestic services such as cleaning) the study examined, among other things, the gig economy’s potential, working practices and consequences for labour and social security law.

The Committee takes note of this information, which is useful but does not give it a full picture of the social security coverage of digital platform workers. It asks for updated and detailed information in the next report on the number of digital platform workers (as a percentage of the total number of workers), their status (employees, self-employed and/or other category), the number/percentage of these workers by status and their social security protection (by status). The Committee also asks whether, on the basis of the studies that have been carried out, measures to improve the social security coverage of digital platform workers have been taken or are planned.

Covid-19

In response to the second question, the Government states that two measures were introduced in 2020 to alleviate the pandemic’s negative impact: the Temporary Emergency Scheme for Job Retention (NOW) and the Temporary Bridging Scheme for Flexible Workers (TOFA). The NOW scheme aims to enable companies affected by the Covid-19 crisis to retain their employees. To this end, the Government paid up to 90% of the companies’ wage costs; a first tranche ran from 1 March to 1 June 2020, and a second tranche from 1 June to 1 October 2020. The TOFA scheme was set up for workers who are not eligible for either unemployment benefits (for example because they have only been employed for a short time) or social assistance benefits (for example because of their partner’s income), provided that they earned a minimum of €400 in February 2020 and no more than €550 in April 2020. Eligible workers were entitled to a one-off payment of €550 per month in March, April and May 2020.

The Netherlands’ Trade Union Confederation points out that domestic workers (under Regulation of Domestic Services) face a problem because under national law, they are excluded from some types of social security coverage. For example, they are not entitled to unemployment benefits and sick pay is limited to six weeks. The Trade Union Confederation adds that the lack of unemployment benefits has left this group of workers extremely vulnerable during the lockdown introduced to tackle the pandemic.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in the Netherlands is in conformity with Article 12§3 of the Charter.

Article 12 - Right to social security

Paragraph 4 - Social security of persons moving between States

The Committee notes that the report does not provide any information concerning this provision of the Charter. Therefore, the Committee reiterates its previous finding of non-conformity.

Conclusion

The Committee concludes that the situation in the Netherlands is not in conformity with Article 12§4 of the Charter on the grounds that:

- the export of social insurance (with the exception of old-age benefits) is not guaranteed in respect of nationals of non-EU States;
- the export of supplementary benefits is not guaranteed in respect of nationals of non-EU States.

Article 13 - Right to social and medical assistance

Paragraph 1 - Adequate assistance for every person in need

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore it will focus on the Government's replies to the targeted questions, namely about measures taken to ensure that the right to social and medical assistance is ensured and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

The previous conclusion (2013) was deferred.

General legal framework, types of benefits and eligibility criteria

The Committee notes from the report that the Participation Act came into effect on 1 January 2015, superseding the Work and Social Assistance Act, the Sheltered Employment Act and a large part of the Work and Employment Support (Young Disabled Persons) Act. The aim of this legislation is, according to the report, to help more people, including those with a work-limiting disability, to find a job. Anyone who is able to work but cannot find their way on the labour market without support, falls under the Participation Act.

Municipalities are responsible for implementing the Act and are expected to support people in the target group to enable them to take up employment. People aged 18 or over who legally reside in the Netherlands, who cannot make use of other social services or benefits and who are not in prison or a remand centre are entitled to social assistance benefit if they have insufficient income or personal wealth to support themselves. Insufficient income means having a single or joint income lower than the minimum income standard. The minimum income standard is usually equivalent to the guaranteed minimum income provided as social assistance benefit.

Levels of benefits

To assess the situation during the reference period, the Committee takes into account the following information:

- Basic benefit: according to the report, a single person without resources received €1025.55 net per month as of 1 January 2019, including the holiday allowance (€ 73.25). Married or cohabiting couples received €1465.07 net per month, including the holiday allowance (€ 73.25). Where beneficiaries aged 21 or older live in the same household as one or more adults with whom they can share costs, a lower amount applies on the basis of the cost-sharing standard.
- Additional benefits: the Committee notes from the MISSOC that in certain cases a person may be eligible for rent allowance, depending, inter alia, on his/her income, rent, assets and age. This is independent from the basic minimum benefit. The report further states that the elderly, the sick, surviving dependants

and people who are partially or totally incapable of work can claim under various other benefit schemes, subject to certain conditions. Under the Social Security Supplements Act, a number of benefits are topped up to the guaranteed minimum income. Various municipal support schemes are available to help people whose income is close or equal to the guaranteed minimum income.

- Medical assistance: the Committee asked in its previous conclusion (Conclusions 2013) to indicate the amount of the average healthcare benefit. There is no information provided in this respect and therefore the Committee reiterates its question. If this information is not provided in the next report, there will be nothing to establish that the situation is conformity with the Charter.
- Poverty threshold (defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value): it was estimated at €1026 per month in 2019.

In the light of the above information, the Committee considers that the level of social assistance is adequate.

Right of appeal and legal aid

The Committee notes that no targeted questions were asked as regards the right of appeal and legal aid. The Committee asks that the next report provide for updated information on the right to appeal and legal aid.

Personal scope

The specific questions asked in relation to Article 13§1 this year do not include an assessment of assistance to nationals of States parties lawfully resident in the territory. Therefore, this particular issue will only be assessed if there was a request of information or a non-conformity in previous cycle.

Foreign nationals unlawfully present in the territory

The Committee recalls that persons in an irregular situation must have a legally recognised right to the satisfaction of basic human material need (food, clothing, shelter) in situations of emergency to cope with an urgent and serious state of need. It likewise is for the States to ensure that this right is made effective also in practice (European Federation of National Organisations working with the Homeless (FEANTSA) v. the Netherlands, Complaint No. 86/2012, decision on the merits of 2 July 2014, §187).

There is no information provided on this point in the report. The Committee refers to its finding about Complaint No. 86, and also about Complaint No. 90, adopted in 2020 (Findings 2019), in which it concluded that as regards the violation of Article 13§1, the situation had been remedied as the right to emergency assistance for adult migrants in an irregular situation and without adequate resources in the Netherlands is guaranteed, and they have access to basic services, including shelter. The Committee considers therefore that the situation is in conformity with the Charter, but it requests the next report to provide updated information on the access of persons in irregular situation to medical and social assistance.

Medical and social assistance during the Covid-19 pandemic

The Committee takes note that, according to the report, since the start of the Covid-19 crisis, the government has been committed to protecting jobs and businesses. In addition, together with municipalities and civil society organisations, it is working to ensure that people experiencing financial difficulties do not end up in a worse situation as a result of the pandemic. The Netherlands has a good infrastructure to support people living in poverty and/or in debt and to help the homeless, with municipalities and civil society organisations playing an important role. With a broad support and recovery package of measures, the government is seeking to help people change jobs or move from unemployment to

employment, provide training, retraining and development opportunities, combat poverty and problem debt, tackle youth unemployment and protect vulnerable groups in the labour market.

The Committee asks the next report to produce further information on social assistance and specific measures taken during the Covid-19 pandemic.

Conclusion

Pending receipt of information requested, the Committee concludes that the situation in the Netherlands is in conformity with Article 13§1 of the Charter.

Article 13 - Right to social and medical assistance

Paragraph 2 - Non-discrimination in the exercise of social and political rights

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the current cycle.

Article 13 - Right to social and medical assistance

Paragraph 3 - Prevention, abolition or alleviation of need

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the current cycle.

Article 13 - Right to social and medical assistance

Paragraph 4 - Specific emergency assistance for non-residents

The Committee takes note of the report submitted by the Netherlands**.**

The Committee recalls that for the purposes of the present report States were asked to reply to targeted questions, as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection"). However, r no targeted questions were posed in respect of Article 13§4. The Committee deferred its previous conclusion in 2013. No information under Article 13§4 is provided in the report.

The Committee refers to Collective Complaints FEANTSA v. The Netherlands, Complaint No. 86/2012 and CEC v. The Netherlands, Complaint No. 90/2013. In its decision of 9 July 2014 on Complaint No. 86, the Committee concluded to a violation of Articles 13§§1 and 4 on the grounds that the right to emergency assistance of adult migrants in an irregular situation and without adequate resources in the Netherlands is not guaranteed and that there is no right to appeal in matters concerning the granting of emergency assistance. In the same date the Committee issued its decision on Complaint No. 90, the Committee concluded to a violation of Article 13§4 on the ground that the practical and legal measures existing in the Netherlands denied the right to emergency assistance to adult migrants in an irregular situation without adequate resources. According to the Findings of 2019, the situation has been remedied in this particular point, as emergency procedures and access to shelter and oter basic needs has been provided for all adult migrants, including those in an irregular situation. The follow up has therefore been closed.

The Committee noted in its 2013 conclusion that foreign nationals lawfully present but without a residence permit are in principle called to bear the costs of the medical care, except in the case of foreign nationals who have submitted a request for a residence permit or are contesting the refusal of such a permit. In addition, all children are granted free access to certain preventive treatment, examinations and dental check-ups and costs for maternal care and birth are fully covered by the National Board of Health Insurances. The Committee asks the next report again to inform on whether non-resident foreign nationals lawfully present without a residence permit who are in need can be waived of the costs of emergency medical care and what are their rights to emergency social assistance. In the meantime, the Committee reserves its position on these issues.

Conclusion

Pending receipt of the information requested, the Committee defers its conclusion.

Article 14 - Right to benefit from social welfare services

Paragraph 1 - Promotion or provision of social services

The Committee takes note of the information contained in the report submitted by the Netherlands, as well as comments by Dutch section of the International Commission of Jurists

The Committee recalls that Article 14§1 guarantees the right to benefit from general social welfare services. It notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely how and to what extent the operation of social services was maintained during the COVID-19 crisis and whether specific measures were taken in view of possible similar crises arising in the future. The Committee wishes to point out that it will take note of the information provided in reply to the question relating to COVID-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the COVID-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

As regards the description of general organisation of social services, the Committee refers to its previous conclusion (Conclusions 2013) in which it found the situation to be in conformity with the Charter. The report does not indicate any changes in this respect.

In response to the targeted questions, the report provides that during the COVID-19 pandemic, the policy (including the Social Support Act, the Chronic Care Act and the Youth Care Act) aimed to guarantee continuity of care in both the short term and the longer term. The government has acknowledged that the COVID-19 crisis is having a huge impact on care providers and health professionals and is taking measures address the financial problems facing care providers as a result of the COVID-19 pandemic. Arrangements have been put in place to compensate care providers, in part for the additional expenses they are incurring and in part for any drop in demand they are experiencing.

A COVID-19 strategy has been developed for people with disabilities and/or underlying health problems (such as a chronic disease). When drawing up and shaping this strategy, the government worked closely with client organisations, industry bodies and professional associations right from the start of the pandemic in order to deal with the crisis in the best way possible. There is weekly consultation between client and patient organisations. The strategy is two-pronged: first, it should help us provide optimum support people with disabilities in coping with the consequences of the crisis for them and, second, it should ensure that ample attention is paid to this target group when planning social distancing measures so that they can continue to participate in society on an equal footing. Furthermore, in the filed of youth care services, the Ministry of Health, Welfare and Sport liaised closely with the entire care sector on this matter and drew up guidelines and practical advice for professionals, parents and young people. In addition, central government and the Association of Netherlands Municipalities reached financial agreements to mitigate the consequences of the crisis for care providers and municipalities.

Conclusion

The Committee concludes that the situation in the Netherlands is in conformity with Article 14§1 of the Charter.

Article 14 - Right to benefit from social welfare services

Paragraph 2 - Public participation in the establishment and maintenance of social services

The Committee takes note of the information contained in the report submitted by the Netherlands, as well as comments by Dutch section of the International Commission of Jurists.

The Committee recalls that Article 14§2 requires States Parties to provide support for voluntary associations seeking to establish social welfare services. The “individuals and voluntary or other organisations” referred to in paragraph 2 include the voluntary sector (non-governmental organisations and other associations), private individuals, and private firms.

The Committee further notes that for the purposes of the current examination, States were asked to reply to the specific targeted questions posed to States in relation to this provision (questions included in the appendix to the letter of 3 June 2020, in which the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the scope of the thematic group “Health, social security and social protection”) as well as previous conclusions of non-conformity or deferrals. States were therefore requested to provide information on user involvement in social services (“co-production”), in particular on how such involvement is ensured and promoted in legislation, in budget allocations and decision-making at all levels, as well as in the design and delivery of services in practice. Co-production is understood here to mean that social services work together with users of the services on the basis of fundamental principles, such as equality, diversity, accessibility and reciprocity.

In its previous conclusion (Conclusions 2013), the Committee found the situation to be in conformity with the Charter. The report provides that in 2018 a new Care Institutions (Patient Participation) Act was adopted. The objectives are to strengthen the position of patients and promote good governance in institutions. This new legislation sets out patient councils’ rights and powers, as well as institutions’ obligations and rights. Institutions above a certain size (i.e. with more than 10 care providers, or in some case with more than 25 care providers) are required to set up a patient council representing the common interests of patients and granting them the right of approval on a whole range of topics, particularly those that directly affect patients, and the right to give an advisory opinion on other topics. The institutions are also required to provide facilities for patient councils and cover expenses for training, meeting facilities and so forth. The Act has a number of additional regulations for institutions providing chronic care, based on the rationale that a long-term stay can have a particularly significant impact on patients’ daily lives. In addition to allowing the patient council to participate in even more decisions, these institutions – regardless of their size – must give all patients (and their representatives) a say in matters that affect their daily lives. The new Act was drafted in close collaboration with organisations of patient councils and organisations of care institutions. A practical guide was also jointly drawn up with these organisations with the aim of promoting and facilitating patient involvement.

Furthermore, the Youth Act (2015) is intended to make more use of the resources of young people, their parents and the family’s social network. The national knowledge network of young people and parents The youth councils in youth care institutions give young people receiving care an opportunity to have their say and get involved. These youth councils are organised nationwide in the Youth Welfare Council. Young people are also involved in the reform of youth care. For example, they are represented in StroomOp, the group of professionals that is implementing the reform of secure youth care. Central government encourages youth participation by providing grants to the National Youth Council and to young advisers with first-hand experience of the youth care system, helping them to make their voices heard at both local and national level. Ministers are also in discussion with young people and youth organisations on relevant policy issues. The Ministry of Health, Welfare and Sport is currently talking to the Netherlands Youth Institute and the National

Youth Council about organising youth participation. At national level, young people and patient organisations are also consulted on proposed legislation. One recent example concerned two bills: one to improve the availability of care for young people and the other on the legal status of secure youth institutions.

The report provides a further example of involvement of people with disabilities and chronic diseases in establishing a strategy for the COVID-19 pandemic and its follow-up.

The Committee asks what measures, including legislative or budgetary, have been adopted or envisaged to foster the user involvement in other fields of social services or whether some general principles are applied in this respect and how they are implemented.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in the Netherlands is in conformity with Article 14§2 of the Charter.

Article 23 - Right of the elderly to social protection

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about measures taken to ensure that the social and economic rights of older persons are respected and Covid-19 and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (namely, after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

The previous Conclusion found the situation not to be in conformity on the grounds that there was no adequate legal framework to combat age discrimination outside employment (Conclusions 2013).

Autonomy, inclusion and active citizenship

Legislative framework

The Committee recalls that Article 23 of the Charter requires State Parties to undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular to enable older persons to remain full members of society for as long as possible. The expression "full members of society" used in Article 23 requires that older persons must suffer no ostracism on account of their age. The right to take part in society's various fields of activity should be ensured to everyone active or retired, living in an institution or not.

The Committee takes due account of contemporaneous definitions of ageism which refer to the stereotypes, prejudices and discrimination directed towards other or oneself based on age (see for example WHO report on Ageism, 2021, p. XIX) As the World Health Organisation has noted, "… ageism has serious and far-reaching consequences for people's health, well-being and human rights"(WHO report on Ageism, 2021, p. XVI).

The Covid-19 crisis has exposed and exacerbated a lack of equal treatment of older persons. This has included in the healthcare context, where there have been instances of rationing of scarce resources (e.g. ventilators) based on stereotyped perceptions of quality of life, vulnerability and decline in old age.

Equal treatment calls for an approach based on the equal recognition of the value of older persons' lives in all the areas addressed by the Charter.

Article 23 of the Charter requires the existence of an adequate legal framework for combating age discrimination in a range of areas beyond employment, namely in access to goods, facilities and services, such as insurance and banking products, allocation of resources and facilities. Discrimination against older persons in terms of social rights enjoyment, is also contrary to Article E.

The overall emphasis in the Charter on using social rights to underpin personal autonomy and respect the dignity of older persons and their right to flourish in the community requires

a commitment to identifying and eliminating ageist attitudes and those laws, policies and other measures which reflect or reinforce ageism. The Committee considers that States Parties, in addition to adopting comprehensive legislation prohibiting discrimination on grounds of age, must take a wide range of measures to combat ageism in society. Such measures should include reviewing (and as necessary amending) legislation and policy for discrimination on grounds of age, adopting action plans to ensure the equality of older persons, promoting positive attitudes towards ageing through activities such as society-wide awareness campaigns, and promoting inter generational solidarity.

Further Article 23 requires that States parties provide for a procedure of assisted decision making.

The Committee previously concluded that the situation was not in conformity with Article 23 of the Charter on the grounds that the legislation prohibiting age discrimination outside employment was inadequate (Conclusions 2013).

The report provides no information on this issue. Therefore the Committee reiterates its previous conclusion.

The Committee previously asked for information on the legal framework related to assisted decision making for older persons (Conclusions 2013). No information is provided in this respect therefore the Committee reiterates is question.

The Committee takes note of the detailed information provided in the report in response to its previous questions on guardianship procedures.

The Committee recalls that there should be a national legal framework related to assisted decision making for older persons guaranteeing their right to make decisions for themselves. Older persons must not be assumed to be incapable of making their own decisions just because they have a particular medical condition or disability.

States Parties must take measures to replace regimes of substituted decision-making by supported decision-making, which respects the person's autonomy, will and preferences. These may be formal or informal.

Older persons may need assistance to express their will and preferences, therefore all possible ways of communicating, including words, pictures and signs, should be used before concluding that they cannot make the particular decision on their own.

In this connection, the national legal framework must provide appropriate safeguards to prevent the arbitrary deprivation of autonomous decision making by older persons. It must be ensured that any person acting on behalf of older persons interferes to the least possible degree with their wishes and rights (Statement of Interpretation 2013).

Prevention of abuse of older persons

The Committee asks for updated information to be provided in the next report, on measures taken to combat abuse of older persons including measures to raise awareness of the need to eradicate older abuse and neglect (beyond the institutional care context), and any legislative or other measures. It also asks whether data has been collected which would indicate the prevalence of older abuse.

Independent living and long term care

The Committee asks whether steps have been taken to move way from the institutionalisation of older persons and adopt a long term care and support in the community model. The Committee recalls that Article 23 provides that measures should be taken to enable older persons to lead independent lives in their familiar surroundings therefore it considers that older persons requiring long term care should be able to choose their living arrangements. In particular, this requires states to make adequate provision for independent living, including housing suited to their needs and state of health, as well as the necessary resources and supports needed to make independent living possible.

Institutionalisation is a form of segregation, often resulting in a loss of autonomy, choice and independence. The Covid-19 pandemic has put the spotlight on the shortcomings of institutionalised care. The Committee refers in this respect to its Statement on Covid-19 and social rights (adopted March 2021) where its stated that enabling older persons to remain in their familiar surroundings as required by Article 23 of the Charter has become even more important in view of the heightened risk of contagion in the congregated settings of nursing homes and other long-term institutional and residential facilities and to the human rights-based argument for investment in the community to give reality to the right to community living is now added a public health argument in favour of moving away from residential institutions as an answer to long term care needs.

The Committee asks the next report to provide updated information on the progress made in providing care in the community, it asks in particular how many older persons reside in institutions- residential care and trends in the area.

Services and facilities

The Committee recalls from previous conclusions that under the Social Support Act (WMO), local authorities are required to take measures to ensure that people can continue to lead independent lives for as long as possible and to enable them to participate in social life. Local authorities provide social services*.* Care is provided generally free of charge, however a personal contribution is required in some cases. Local authorities can also provide an allowance, allowing the recipients to purchase the support they need (Conclusions 2013).

The Committee asks the next report to provide updated information on the range of services and facilities available to older persons, including long term care, in particular those enabling them to remain active members of their community and to remain in their home as well as information on the costs of such services. It also asks whether there is an adequate supply of care services, including long term care services and whether there are waiting lists for services.

The Committee previously asked whether information, training and respite care was available for families caring for older persons, in particular highly dependent persons (Conclusions 2013) No information is provided in the report. The Committee asks what support is available for informal carers.

The Committee notes that many services (and information about services) are increasingly accessible online. Digitalisation provides opportunities for older persons. However older persons may have more limited access to the internet than other groups and may lack the necessary skill to use it. Therefore the Committee asks what measures have been taken to improve the digital skills of older persons, ensure the accessibility of digital services for older persons, and ensure non-digital services are maintained.

Housing

The Committee asks the next report to provide information on how the needs of older persons are taken into account in national or local housing policies and strategies as well as information on the supply of sheltered/supported housing and the range of accommodation options for older persons.

Health care

The Committee asks that the next report provide information on healthcare programmes specifically designed for older persons.

The Committee notes that the pandemic has had devastating effects on older persons' rights, in particular their right to protection of health (Article 11 of the Charter), with consequences in many cases for their rights to autonomy and to make their own decisions and life-choices, their right to continue to live in the community with adequate and resilient supports to enable them to do so, as well as their right to equal treatment in terms of Article

E when it comes to the allocation of health care services including life-saving treatments (e.g., triage and ventilators). Whether still living independently or not, many older persons have had their services removed or drastically reduced. This has served to heighten the risk of isolation, loneliness, hunger and lack of ready access to medication.

Further the Covid-19 crisis has exposed examples of a lack of equal treatment of older persons, too much space was allowed for implicit judgments about the 'quality of life' or 'worth' of lives of older persons when setting the boundaries for such triage policies.

The Committee also asks whether decisions around the allocation of medical resources may be made solely on the basis of age, and asks whether triage protocols have been developed and followed to ensure that such decisions are based on medical needs and the best scientific evidence available.

Institutional care

The Committee previously asked for more information on the monitoring/inspections of institutional care and the costs of institutional care (Conclusions 2013). No information is provided in this respect. The Committee asks the next report to provide this information.

The Committee notes from information provided in the report under Article 14 of the Charter that a new Care Institutions (Patient Participation) Act 2018, was adopted. The objectives are to strengthen the position of patients and promote good governance in institutions. This new legislation sets out patient councils' rights and powers, as well as institutions' obligations. Institutions above a certain size) are required to set up a patient council representing the common interests of patients. Patient councils have the right of approval on a whole range of topics, particularly those that directly affect patients, and the right to give an advisory opinion on other topics. The Act has a number of additional regulations for institutions providing long term care. These institutions – regardless of their size – must give all patients (and their representatives) a say in matters that affect their daily lives.

The Committee refers to its statement above on the importance of moving away from institutional care and towards care in the community.

The Committee considers that the overall emphasis in the Charter on personal autonomy and respect for the dignity of older persons, results in a pressing need to re-invest in community-based supports as an alternative to institutions. Where, in the transition period, institutionalisation is unavoidable, Article 23 requires that living conditions and care be adequate and that the following basic rights are respected: the right to autonomy, the right to privacy, the right to personal dignity, the right to participate in decisions concerning the living conditions in the institution, the protection of property, the right to maintain personal contact (including through internet access) with persons close to an older person person and the right to complain about treatment and care in institutions. This also applies in the Covid-19 context.

Due to the specific Covid-19 related risks and needs in nursing homes, States Parties must urgently allocate sufficient additional financial means towards them, organise and resource necessary personal protective equipment and ensure that nursing homes have at their disposal sufficient additional qualified staff in terms of qualified health and social workers and other staff in order to be able to adequately respond to Covid-19 and to ensure that the above mentioned rights of older people in nursing homes are fully respected.

Adequate resources

When assessing adequacy of resources of older persons under Article 23, the Committee takes into account all social protection measures guaranteed to older persons and aimed at maintaining income level allowing them to lead a decent life and participate actively in public, social and cultural life. In particular, the Committee examines pensions, contributory or non-contributory, and other complementary cash benefits available to older persons. These resources will then be compared with median equivalised income. For this purpose, the

Committee will also take into consideration relevant indicators relating to at-risk-of-poverty rates for persons aged 65 and over.

The Committee previously found that the guaranteed old-age benefit was above the poverty threshold as defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value (Conclusions 2013). However it noted from Eurostat that in 2011, 1.8% of persons aged 65 had income falling below 40% of the median equivalised income The Committee requested information on measures taken to address this situation (Conclusions 2013).

The reports provides general information on the old age pension system in the Netherland but no information on the amounts or on the number of persons over 65 with income falling below the poverty threshold.

The Committee notes from MISSOC that the amount of the state pension payable after 50 years insurance was in July 2019 €1,228.22 per month for a single person, and €843,78 for married and unmarried persons sharing a household each. 2% is deducted for each year not insured. If persons are not eligible for a full pension supplements maybe payable to increase the income to the guaranteed minimum income.

The poverty threshold, defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value, was estimated at €1,026 in 2019. The Committee notes that the full pension is adequate. However it asks the next report to provide updated information on the guaranteed minimum income for older persons, and information on the percentage of persons having an income falling below 40% of the median equivalised income as well as on measures taken to address their situation.

Covid-19

The Committee asked a targeted question on measures taken to protect the health and well being of older persons in the context of a pandemic crisis such as Covid-19.

According to the report to protect older persons in institutional settings (care homes), the Ministerial Crisis Management Committee decided on 19 March 2020 to preventively close care homes and small-scale residential homes for older people to visitors and anyone else who was not essential for basic care.

The National Institute for Public Health and the Environment (RIVM) produced guidelines on the use of PPE by care workers and on the testing for patients and care workers.

Specialists in geriatrics have drawn up treatment guidelines, setting out the correct diagnosis, prevention and treatment of residents with Covid-19.

Neighbourhood social support teams and a large volunteers' network assisted people during lockdown. In addition, municipalities made every effort to ensure that the most vulnerable groups continued to receive care and support.

To keep people in the local community properly informed, municipalities have created a Covid-19 web page and several have also sent a letter to older residents or all residents to let them know where they can get help.

The Ministry of Health, Welfare and Sport also continues to consult with care and support organisations, patients, clients, older people and municipalities to discuss what is needed and how we can keep working together to prevent a second wave as far as possible and ensure that people with health issues can continue to participate in society.

The Committee refers to the section on older persons in its statement on Covid-19 and Social Rights (March 2021) (and to sections cited above). It recalls Article 23 requires that older persons and their organisations be consulted on policies and measures that concern them directly, including on ad hoc measures taken with regard to the current crisis. Planning for the recovery after the pandemic must take into account the views and specific needs of

older persons and be firmly based on the evidence and experience gathered in the pandemic so far.

Conclusion

The Committee concludes that the situation in the Netherlands is not in conformity with Article 23 of the Charter on the ground that there is no legislation prohibiting age discrimination outside employment.

Article 30 - Right to be protected against poverty and social exclusion

The Committee takes note of the information contained in the report submitted by the Netherlands.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions related to this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter with respect to the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about measures (legal, practical and proactive, including some concerning supervision and inspection) taken to ensure that no person falls below the poverty threshold, during or after the Covid-19 crisis, the impact of these measures and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 which relates to developments outside the reference period (namely, after 31 December 2019) for information purposes only. In other words, the information referred to in this section – "Poverty and social exclusion in times of the Covid-19 crisis" – will not be assessed for the purposes of Charter compliance in the current reporting cycle.

In its previous conclusion, the Committee found that the situation in the Netherlands was in conformity with Article 30 of the Charter (Conclusions 2013).

Measuring poverty and social exclusion

The Committee recalls that, under Article 30, States Parties must provide detailed information on how they measure poverty and social exclusion. The main indicator used by the Committee to measure poverty is the relative poverty rate. This corresponds to the percentage of people living under the poverty threshold, which is set at 60% of the equivalised median income.

The Committee notes that the report provides statistics on poverty, based on Eurostat figures. It observes that the at-risk-of-poverty rate (cut-off point: 60% of the median equivalised income after social transfers) was low, but increased slightly during the reference period, from 12.7% in 2016 to 13.2% in 2019 (the rate in the EU-28 reached 17.3% in 2016 and 16.8% in 2019). It also observes that there was practically no difference in the at-risk-of-poverty rate (after social transfers) between men and women (a difference of under 0.5% during the reference period).

The at-risk-of-poverty rate of the unemployed (aged 16 to 64) increased during the reference period, from 44.7% in 2016 and 46.9% in 2018, to 54.1% in 2019. The Committee observes, however, that these figures were lower than the EU-28 average at the beginning of the reference period (48.7% in 2016 and 2018, but 48.6% in 2019). By contrast, the at-risk-of-poverty rate among the employed (aged 16 to 64) declined during the reference period (5.6% in 2016, 6.1% in 2017 and 2018 and 5.4% in 2019); these figures were under half the EU-28 averages in the period (9.6% in 2016, 9.4% in 2017 and 2018 and 9.2% in 2019 respectively).

The at-risk-of-poverty rate (cut-off point: 60% of the median equivalised income after social transfers) among persons over 65 was low too, but increased slightly during the reference period, from 9% in 2016 to 11.8% in 2019 (compared to 5.6% in 2015 or 5.2% in 2012). The Committee notes that these figures were still well below the EU-28 average (14.5% and

16.5% respectively). As regards children (younger than 16), the at-risk-of-poverty rate decreased slightly over the reference period, from 14.8% in 2016 to 13.6% in 2019.

Comparing at-risk-of-poverty rates before and after social transfers, the Committee also notes that the impact of social benefits has slightly decreased during the reference period (from 9.4% in 2016 and 8.5% in 2018, to 8.1% in 2019).

Concerning the risk of poverty and social exclusion (AROPE), which according to Eurostat methodology (see also Conclusions 2013 in this respect), corresponds to the sum of the persons who are (1) at risk of poverty; and/or (2) face severe material deprivation; and/or (3) live in a household with very low work intensity, the Committee observes that 16.7% of the population was at risk of poverty and social exclusion in 2016, 17% in both 2017 and 2018, and 16.5% in 2019 (in the EU-28, the rates were 23.5% in 2016 and 21.4% in 2019 respectively).

As regards children (younger than 16), the risk of poverty and social exclusion decreased slightly during the reference period, from 17.2% in 2016 to 15.3% in 2019. The Committee observes that these rates were well below the averages in the EU-28 (25.9% and 23.1% respectively).

The Committee notes that the indicators measuring poverty and income inequalities are low, falling well below the EU average.

Approach to combating poverty and social exclusion

The report states that the government is committed to preventing poverty via a four-pronged approach:

- (1) Labour market policy: promoting employment and encouraging more social assistance benefit claimants to find a job.
- (2) Incomes policy: focusing on the purchasing power of people with low incomes and ensuring that work is actually paid.
- (3) Income guarantee policy: guaranteeing that everyone can rely on a minimum income.
- (4) Child poverty policy: promoting the social support of every child in a low-income family and reducing the number of children growing up in poverty.

According to the report, there two specific measures were launched: the Comprehensive Approach to Tackling Debt (*Brede Schuldenaanpak*) and Child Poverty Ambitions (*Ambities Kinderarmoede*).

As regards the former initiative, the report indicates that, since 2018, the government, in cooperation with municipalities, implementing organisations and civil society organisations, has been working on rolling out the Action Plan, which includes more than 40 measures to tackle debt problems.

As regards the latter initiative, the report indicates that, in 2019, four objectives were set to further reduce child poverty: (1) every child growing up in a low-income family is eligible for social assistance; (2) the number of low-income households with children is to be reduced over the next few years; (3) there will be regular reviews of social exclusion among children; and (4) good practices and initiatives are to be identified by municipalities and other local and national organisations, aimed in order to prevent child poverty and its adverse effects on children. The report indicates that various measures have been implemented to achieve these objectives. The Committee has already noted that the at-risk-of-poverty rate and the risk of poverty and social exclusion of children (younger than 16) decreased during the reference period. It asks that information on the achievement of these goals be provided in the next report.

The Committee notes from the European Semester Country Report – Netherlands 2019, that the Netherlands has some of the lowest at-risk-of-poverty and social exclusion rates, and the country is still among the top performers, with a low level of poverty.

The Committee also refers to its conclusions of non-conformity regarding other relevant provisions of the Charter for an assessment of conformity with Article 30 (see Conclusions 2013 and the Statement of interpretation on Article 30). It refers in particular to:

- Article 7§5 and its conclusion that young workers' wages were not fair and that apprentices' allowances were not adequate (Conclusions 2015);
- Article 12§4 and its conclusion that the export of social insurance (with the exception of old-age benefits) and of supplementary benefits are not guaranteed in respect of nationals of non-EU States (Conclusions 2021).

The Committee refers to its third assessment of follow-up on the Complaint No. 86/2012, European Federation of National Organisations Working with the Homeless (FEANTSA) v. the Netherlands (decision on the merits of 2 July 2014), where it noted that "on the basis of the information available to it, in particular the high number of persons remaining homeless, the Committee is still unable to conclude that access to a shelter, including a shelter for the homeless, for the purpose of preventing homelessness is ensured and that the quality and quantity of shelters available to vulnerable groups fulfil the requirements of Article 30 of the Charter concerning the right to protection against poverty and social exclusion".

On the basis of all information at its disposal and notably the low level of poverty rates, the Committee considers that the situation remains in conformity with Article 30. However, the Committee asks what specific measures are being taken to combat poverty and social exclusion among migrants and other vulnerable groups.

Monitoring and evaluation

In its previous conclusion, the Committee examined how individuals and voluntary associations take part in assessing measures to combat poverty and found that the situation was in conformity on this point (Conclusions 2013).

The Committee asks for the updated information on monitoring and evaluation of the effort to combat poverty and social exclusion to be provided in the next report.

Poverty and social exclusion in times of the Covid-19 crisis

The report indicates that, since the start of the Covid-19 crisis, the government has been committed to protecting jobs and businesses. In addition, together with municipalities and civil society organisations, it is working to ensure that people experiencing financial difficulties do not end up in a worse situation as a result of the pandemic (people living in poverty and/or in debt, the homeless). The report states that thanks to an additional package of social measures within the broad support and recovery package, the government has set aside about €1.4 billion for the period 2020-2022 to help people change jobs or move from unemployment to employment, to provide training, retraining and development opportunities, to combat poverty and debt problems, to tackle youth unemployment and protect vulnerable groups on the labour market. A total of €150 million will be made available to combat poverty and debt problems.

The Committee notes that the Social Support Act makes municipalities responsible for providing shelter and support for the homeless. After the outbreak of the Covid-19 pandemic, the Ministry of Health, Welfare and Sport published guidelines calling on municipalities to take additional measures to organise services for homeless people in accordance with the national guidelines for combating the virus. The Committee takes note of the measures prescribed, and observes that, according to the report, the central government has compensated municipalities for the cost of these measures.

Conclusion

The Committee concludes that the situation in the Netherlands is in conformity with Article 30 of the Charter.