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EUROPEAN SOCIAL CHARTER

14th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF THE NETHERLANDS

Articles 3, 11, 12, 13, 14, 23 and 30

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CYCLE 2021

THE EUROPEAN SOCIAL CHARTER

The Netherlands' Thirty-third Report

for the period 1 January 2016 - 31 December 2019

Report

For the period 1 January 2016 to 31 December 2019, made by the Government of the Netherlands in accordance with Article C of the Revised European Social Charter, on the measures taken to give effect to the accepted provisions of the European Social Charter.

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

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

- Netherlands Trade Union Confederation (FNV)
- National Federation of Christian Trade Unions in the Netherlands (CNV)
- The Confederation of Netherlands Industry and Employers (VNO-NCW)

Appendix

Questions on Group 2 provisions (Conclusions 2021) Health, social security and social protection

At the outset, the European Committee of Social Rights wishes to clarify that these questions and the Conclusions are not intended to form the basis for a full assessment of the efforts made by States to combat the COVID-19 epidemic. However, in the current circumstances it is justified and unavoidable to take COVID-19 into account, not least because the responses to the crisis have been shaped by measures taken and implemented during the reference period. While acknowledging that the responses were made after the reference period, the Committee therefore invites States to provide information on them and on the (provisional) results achieved, in so far as possible and as indicated in the questions set out below.

The Committee is aware of the exceptional circumstances resulting from the pandemic and the COVID- 19 crisis. National administrations have been confronted with considerable demands and very difficult choices and decisions, and society as a whole has been placed under enormous strain. COVID-19 has brought about much suffering and for many different reasons.

Human rights, including their social rights dimension, permit the safeguarding of the most fundamental values of our societies over time, including through exceptionally difficult times. As stated in the very first provision of the Statute of the Council of Europe, the aim of the Organisation is to achieve a greater unity between its members for the purpose of safeguarding and realising the ideals and principles which are their common heritage and facilitating their economic and social progress. The need to pursue this objective is not suspended but, on the contrary, reinforced in times of crisis.

The thematic group of European Social Charter provisions on which States Parties are due to report for Conclusions 2021 — health, social security and social protection — and the reference period (2016 to 2019) were of the greatest importance for the shaping of responses during the COVID-19 crisis. The Committee also wishes to draw attention in this respect to its recent statement of interpretation on the right to health adopted on 21 April 2020.

The provisions in question should also inspire longer-term decisions once the worst of the pandemic is over. The Committee expects that the COVID-19 pandemic will continue to be a recurring theme in the reporting procedure over the coming years, when it will be examining other thematic groups of provisions, on labour rights, on children, family (and women) and migrants rights.

The Committee understands that, while administrations and staff may be stretched, the answers to questions related to the COVID-19 may be more readily available in the coming months. It has attempted to formulate

questions in a focussed manner, preceded by some explanatory elements, but will welcome broader responses that allow for a comprehensive understanding of the human and social rights-based response given by states to the COVID-19 crisis in light of the arrangements that were in place during the reference period (2016 to 2019).

Continuing the targeted and strategic approach initiated in 2019 (for Conclusions 2020), Conclusions 2021 will focus on the questions set out below. In this respect, the Committee recalls the decision adopted by the Committee of Ministers on 11 December 2019 whereby it "took note with interest of the steps taken by the ECSR to simplify the reporting procedure under the European Social Charter, focusing on issue-based questions on selected provisions, and invited the ECSR and the Governmental Committee to consider further ways of streamlining the procedure, including the advisability of reviewing the current system of thematic reports". The strategic and targeted approach also implies that the Committee does not request any additional information in respect of certain Charter provisions (for example Article 12§1 and 12§4), unless the previous conclusion was one of non- conformity or when it was deferred due to lack of information.

On account of the difficulties resulting from the current crisis, the Committee exceptionally proposes to extend the deadline for state reports to 31 December 2020 (and not 31 October which is the usual deadline).

The right of every worker to a safe and healthy working environment is a widely recognised principle, stemming directly from the right to personal integrity. It is closely linked to various rights protected by the Charter and also by the European Convention on Human Rights. As work environments evolve, so do the risks to health and safety that workers are exposed to. There are emerging or relatively new and there are also neglected factors that can affect health, both in the short and the medium or long terms. Of course, the right to safe and healthy working conditions applies to all workers, whether public or private sector employee, and also to the self-employed.

Certain occupations involve assumed or accepted exposure to risk (e.g. cycle delivery services, including those linked to the platform economy; performers in the contact sports entertainment industry; certain jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive substances; etc.). Other work settings also involve risks, for example when they demand ongoing intense attention (e.g. operators of certain types of machinery, vehicles or even computers) or there is an expectation of high performance or increasing output or productivity sometimes associated or conducive to off-label use of medications or of stimulants procured in illegal markets (e.g. new forms of high yield trading; performers in the sports entertainment industry, etc.).

There may also be persistent or recurring stress or even traumatic situations at work (for example in the military, law enforcement or health care) which can sometimes be associated to growing industry demands or poor employer response to problematic situations (for example related to harassment or poor management). Ubiquitous supervision or monitoring using digital technology can also affect the health of workers as can the expectation of responsiveness or almost permanent availability.

A human rights and positive obligations approach requires ongoing attention as well as fostering and preserving a culture of prevention in the areas of health and safety as opposed to purely curative or compensatory approaches. The policies and strategies adopted must be regularly assessed and reviewed, particularly in the light of changing risks.

Exposure of frontline staff to SARS-CoV-2 and the risk of developing COVID-19 placed the right to safe and healthy working conditions under the spotlight. Issues may arise both from the angle of risk of infection because of the objective working conditions (high risk settings, close contact with highly contagious patients, emergency or intensive care units), the material and other arrangements surrounding that kind of work, and the means of protection provided to frontline workers, in terms of instructions, training as well as the quantity and adequacy of protective material. In a crisis, such as the one resulting from the COVID-19 pandemic, the large degree of unpredictability does not exclude preparedness and anticipation which is due not only to the population at large (under Article 11 of the Charter) but also to workers under Article 3 of the Charter. Beyond general preparedness, good governance arrangements must be in place enabling quick reaction and appropriate decision making as the crisis evolves in light of the best information and science available.

Article 3 – The right to safe and healthy working conditions

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

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;

a) *Please provide information 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; also provide information on the results of such processes and of intended future developments.*

Policy on occupational safety and health in the Netherlands

The aim of occupational safety and health policy is to ensure safe and healthy working conditions for all workers. The policy sets out the Dutch government's commitment to achieving that goal. The guiding principle is that employers and employees share primary responsibility for maintaining a safe and healthy working environment, since it is they who determine the actual working conditions in the workplace.

Comment FNV: Formally the employers have the responsibility to assure a workplace complying with OSH standards.

Broadly speaking, the policy has three main thrusts.

Legislation: the responsibility of employers and employees for occupational safety and health is enshrined in law,as are the way in which this responsibility should be discharged and the main occupational risks that need to be managed.**Comment FNV: The responsibility of the employers is legally described. Workers only have a limited, derivative responsibility as far as their own behaviour is concerned.**

Response of the Dutch government to the comment of FNV:

Employers have the responsibility to assure a workplace complying with OSH standards, and they have to instruct employees and provide them with the necessary work equipment and PPE. The employee is obliged to take care of his own safety and health and that of the other persons involved in his actions at the workplace, by using the necessary work equipment and PPE in accordance with his training and the instructions given by the employer.

The statutory rules are in line with EU legislation. The Social Affairs and Employment Inspectorate (formerly the Labour Inspectorate) monitors compliance with these rules.

Comment FNV: Only when noncompliance implies a legal sanction.

Encouragement: the government encourages employers and employees to take an active role in ensuring occupational safety and health. Through consultation with employers' and employees' organisations, campaigns and targeted enforcement programmes, employers and employees are urged to work actively on creating safe and healthy working conditions.

Comment FNV: This is all very non-committal.

Support: the government supports employers and employees in achieving safe and healthy working conditions. This includes developing knowledge and tools relating to the main occupational risks and measures.

An extensive monitoring and research programme has been devised to track how working conditions are changing in the Netherlands. Current working conditions are documented through large-scale surveys of employees, employers and self-employed people and through research.

Policy development

The exact details and focus of policy change over time and are based on new insights into working conditions and how they can be influenced.

Apart from the actual working conditions, political opinion and stakeholder feedback on the current policy are decisive factors when formulating policy.

In broad terms, the development of occupational safety and health policy takes place in cycles. If current policy does not adequately address current challenges and circumstances – resulting, for example, from developments in

society – a process is initiated to update it or devise a new policy plan. This has been done every five to eight years in the past few decades. The policy plan usually spans several years and sets out how the government will promote safe and healthy working conditions for all workers during that period. If there is a change of government during the term of a policy plan, parts of the plan are revised. The general policy priorities and available funding each year are set out in the government's budget. These are fleshed out in a policy programme (annual plan) and a programme for monitoring compliance with legislation.

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 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;
- Opinions 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;
- Results of research into occupational risks, for example on new and emerging hazards.

The government recently began working on a new policy plan for the next few years, as it was felt that the current plan falls short in addressing a number of topical issues and that policy has stalled in some areas. Topical issues concern changes in labour relations, the accelerating development of digital technology, the focus on efficient deployment of labour, improved understanding of today's occupational risks, and a new political environment. The policy pursued in recent years is under close scrutiny and the building blocks for a new multiannual policy plan are being put in place in consultation with employers' and employees' organisations and other relevant stakeholders. The discussions between employers' and employees' organisations, the main stakeholders and the legislature (the government and parliament) about the current situation and the challenges for the future are essential and provide the basis for a broad outline of the policy plan for the years ahead. In consultation with the parties involved, the key points are being worked out in more detail in general policy guidelines and a policy programme for the next several years.

b) With particular reference to COVID-19, provide specific information on the protection of frontline workers (health-care staff including ambulance crews and auxiliary staff; police and other first responders; police and military personnel involved in assistance and enforcement; staff in social-care facilities, for example for older people or children; prison and other custodial staff; mortuary services; and others involved in essential services, including transport and retail; etc.). Such information should include details of instructions and training, and also the quantity and adequacy of personal protective equipment provided to workers in different contexts. Please provide analytical information about the effectiveness of those measures of protection and statistical data

on health outcomes.

Guidelines and procedures on new coronavirus (COVID-19) are available, for example the COVID-19 guidelines issued by the National Coordination Structure for Infectious Disease Control (LCI). This information is 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 Dutch Federation of Medical Specialists (*Federatie Medische Specialisten*) has also drawn up a separate policy on the testing and deployment of healthcare workers in hospitals.

During the COVID-19 pandemic there were severe shortages of CE-marked personal protective equipment (PPE) and medical devices used by healthcare professionals, such as gloves, face masks and gowns. In response, 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 soon as possible. It quickly became apparent that some of the non-CE-marked respiratory protective equipment purchased did not fully comply with the performance specifications claimed by the manufacturer. Since the quality of these non-CE-marked products was not known, 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, bringing together expertise from within and outside the organisation. The team's primary task is to assess the quality of goods purchased by the LCH so that only PPE of sufficient quality is released for use.

Comment FNV: Outside the healthcare system, a lot of unreliable face masks are used, at least face masks of which the soundness has not been demonstrated.

c) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.*

2. to issue safety and health regulations;

a) *Please provide detailed information on the regulatory responses adopted to improve occupational safety and health in connection with known and also evolving or new situations (including as regards stress and harassment at work; work-related substance use and employer responsibility; strictly limiting and regulating electronic monitoring of workers; mandatory digital disconnection from the work environment during rest periods*
– also referred to as "digital detox"; health and safety in the digital and platform economy; etc.) and

about regulatory responses to newly recognised forms of professional injury or illness (such as work-related self-harm or suicide; burn-out; alcohol or other substance use disorders; post-traumatic stress disorders (PTSD); injury and disability in the sports entertainment industry, including in cases when such injury and disability can take years or even decades to become apparent, for example in cases of difficult to detect damage to the brain; etc.).

Under the Working Conditions Act, employers are required to pursue a policy aimed at preventing or reducing work-related stress. The Social Affairs and Employment Inspectorate monitors whether employers and employees are complying with the law. The number of burnout cases has seen an upward trend in recent years. The Dutch government has commissioned research into the underlying causes of burnout in the workforce in relation to work-life balance. In December 2019 an interim report was published on the growing prevalence and possible causes of burnout. Further research will be carried out in 2020. This year will also see the launch of a broad project to tackle burnout from the bottom up. The appointment of a confidential adviser may form part of an employer's policy to prevent or reduce work-related stress. At the moment the focus is on providing information and further professionalising the work of confidential advisers. One measure that employers can take to create a safe and supportive working environment and discourage inappropriate behaviour in the workplace is to draw up a code of conduct.

b) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

3. to provide for the enforcement of such regulations by measures of supervision;

a) Please provide 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.

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 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*

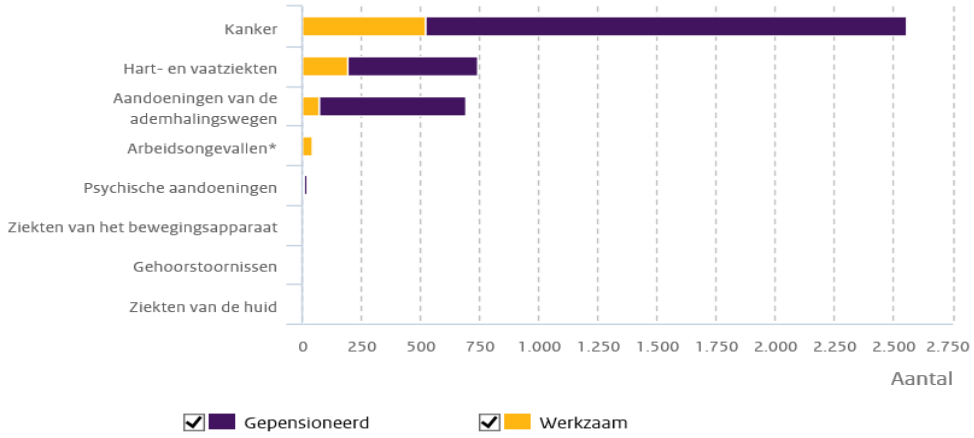
Enquête Arbeidsomstandigheden, NEA), a large-scale survey of more than 40,000 employees who give their opinion on their working conditions and can report whether they have an illness or disease caused by their work. This self-reported data differs considerably from the notifications made to the NCvB.

Work-related death in the Netherlands

In 2005 and 2010 two studies were carried out into work-related death in the Netherlands,[1] 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 RIVM, which now regularly updates the figures. The RIVM data is based on epidemiological research rather than on actually diagnosed cases. The most recent findings are shown in the Figure below. It shows 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 700 deaths due to respiratory disease caused by workplace exposure to hazardous substances (see Figure below).

Causes of work-related death in the Netherlands



Cancer

Cardiovascular disease

Respiratory disease

Workplace accidents*

Mental disorders

Musculoskeletal disorders

Hearing impairment

[1] J. Popma (2005), *Werk gerelateerde sterfte in Nederland: Een verkenning* [Exploratory study into work-related mortality in the Netherlands], Amsterdam: FNV; G. van der Laan et al. (2010), *Sterfte door werk in Nederland: Verkennend onderzoek in het kader van Workers Memorial Day* [Exploratory study in the context of Workers Memorial Day], Amsterdam: Nederlands Centrum voor Beroepsziekten (NCvB).

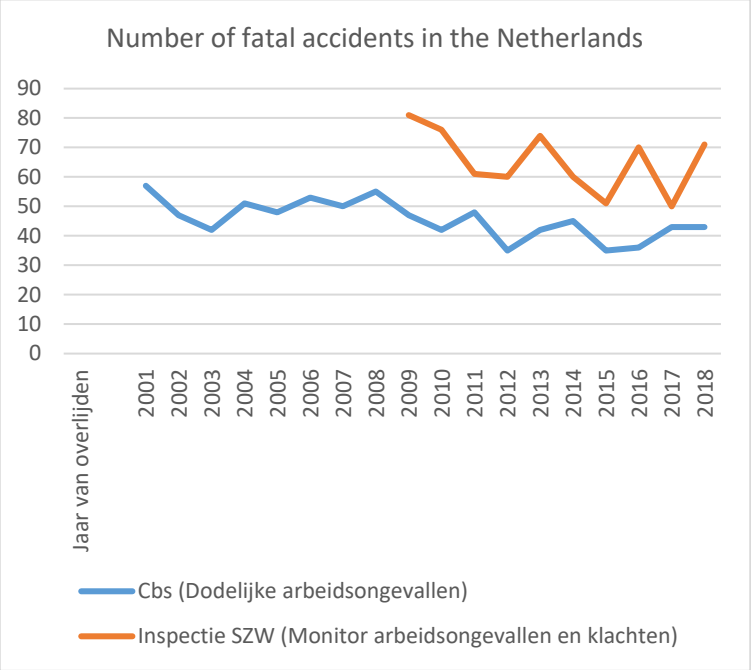
Skin disease

Number

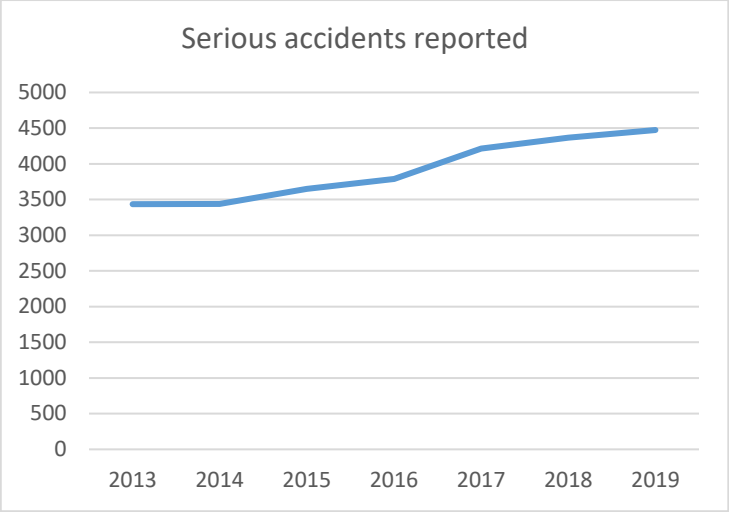
Retired Working

Source: [Volksgezondheidenzorg (gateway to information about public health and healthcare), occupational illness/disease figures, estimated deaths due to occupational illness/disease]

The number of fatal workplace accidents reported in the Netherlands has been below 50 per annum for years.[2]



[2] Statistics Netherlands (CBS) (2020), *Dodelijke arbeidsongevallen 2014-2018* [Fatal workplace accidents 2014-2018]; TNO (2019), 'Arbobalans 2018' [2018 Health and Safety Review], p. 114. The standardised number of fatal workplace accidents in the Netherlands is 0.7 per 100,000 employees. The total number of accidents is around 240,000 (3.4%), of which more than 100,000 result in at least one day of absence. The percentage of employees who have had an accident at work has fluctuated between 3.0 and 3.4% over the past five years.



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.

This text has been adjusted after comments of the FNV to describe the situation more clearly.

Occupational illness in the Netherlands

Company doctors in the Netherlands are required to report occupational illnesses to the NCvB. These 'official' notifications (approximately 4,000 a year) are only the tip of the iceberg, however. 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.

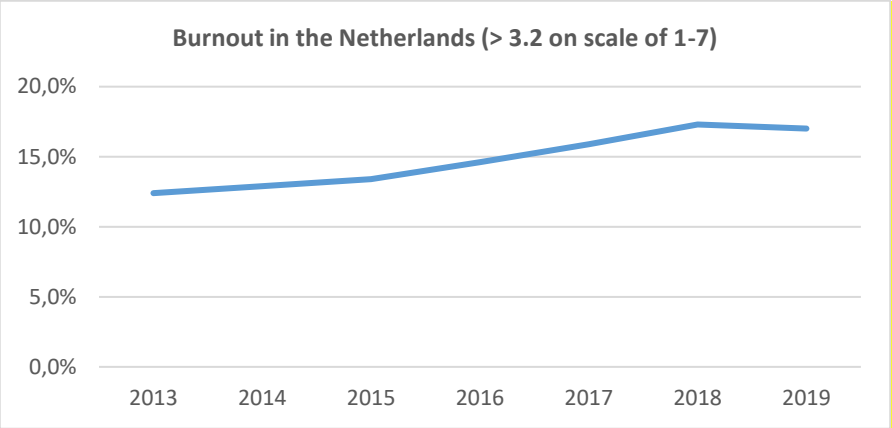
	NCvB notifications (2018)	NEA estimate 2016 (TNO/ Statistics Netherlands)
Occupational illnesses (absolute number of individuals)	3,854	222,600
Physical stress		1.6%
Work-related stress		1.5%
Hazardous substances		0.2%
Other		0.5%
Total (as %)		3.2%

Source: NCvB (2019), Kerncijfers beroepsziekten 2019 [Key figures for occupational illness 2019] and TNO (2019), 'Arbobalans 2018' [2018 Health and Safety Review], p. 141ff.

Mental health problems caused by work

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).

Burnout in the Netherlands



Source: TNO (2016-2019), Netherlands Working Conditions Survey.

Of the occupational illnesses reported to the NCvB in the 'mental health' category, emotional exhaustion and burnout also appear to be the largest diagnostic category by far. PTSD is another significant category, with around 300 notifications per year.

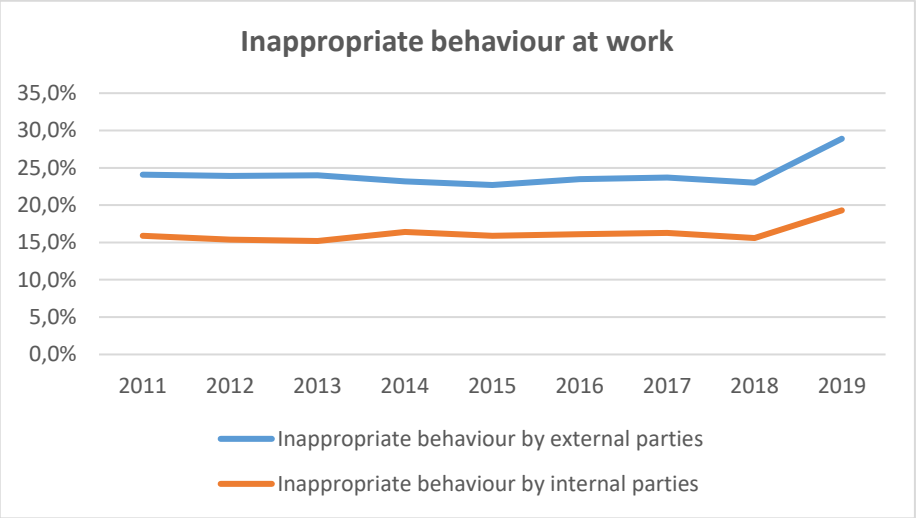
Diagnosis	2015		2016		2017		2018		2019	
	N = 2631	%	N = 2613	%	N = 2639	%	N = 2249	%	N = 2222	%
Emotional exhaustion and burnout	1989	75.6	1941	74.3	1962	74.3	1712	76.1	1664	74.9
Post-traumatic stress disorder	289	11	309	11.8	319	12.1	245	10.9	298	13.4
Depression	146	5.5	130	5.0	129	4.9	102	4.5	94	4.2
Other reactions to severe stress	90	3.4	118	4.5	127	4.8	83	3.7	84	3.8
Other problems	117	4.4	115	4.4	102	3.9	107	4.8	82	3.7

Source: NCvB

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). Broadly speaking, a quarter of all Dutch employees are subjected to inappropriate behaviour by external parties at least once a year, and one in six by colleagues. It is worth noting that there has been a clear increase in recent years (see Figure below), largely due to a different methodology being used in the 2019 survey.

Trends in inappropriate behaviour at work



The main form of inappropriate behaviour is harassment by customers or colleagues.

	2016	2017	2018	2019
Inappropriate behaviour by external parties (customers, patients, pupils, passengers, etc.)	**23.5%**	**23.7%**	**23.0%**	**28.9%**
Unwanted sexual advances	5.5%	6.0%	5.3%	8.4%
Harassment	19.2%	19.1%	18.7%	23.6%
Physical violence	5.8%	5.8%	5.8%	7.3%
Bullying	5.5%	5.5%	5.8%	7.9%
Inappropriate behaviour by internal parties	**16.1%**	**16.3%**	**15.6%**	**19.3%**
Unwanted sexual advances from managers or colleagues	2.1%	2.1%	2.2%	3.1%
Harassment by managers or colleagues	11.1%	11.4%	10.7%	13.2%
Physical violence by managers or colleagues	0.5%	0.4%	0.6%	0.8%
Bullying by managers or colleagues	8.3%	8.2%	8.0%	10.1%
Discrimination in the workplace	Not known	5.6%	Not known	7.6%

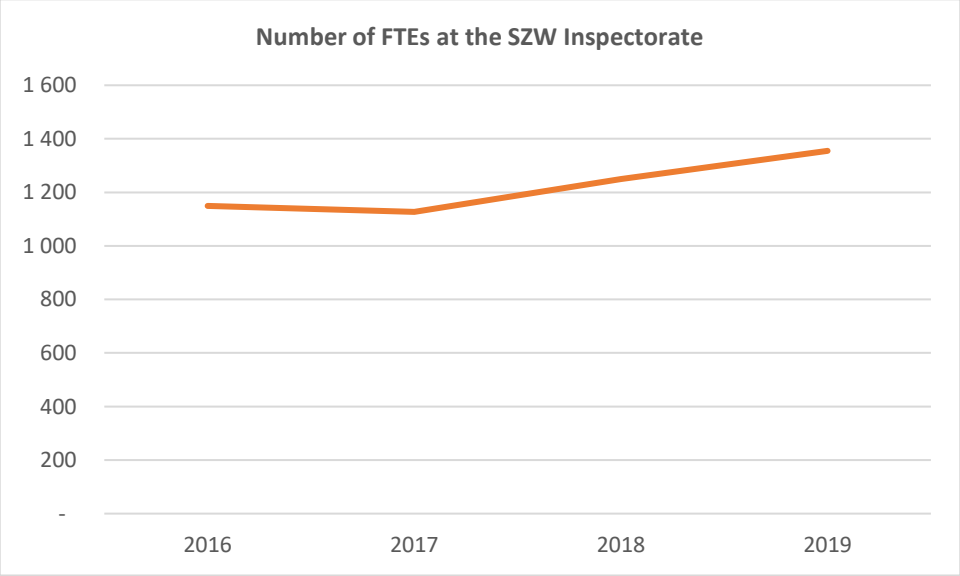
b) Please provide updated information on the organisation of the labour inspectorate, and on the trends in resources allocated to labour inspection services, including human resources. Information should also be

provided on the 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 on the number of breaches to health and safety regulations and the nature and type of sanctions.

Tasks, organisation and resources

The SZW Inspectorate seeks to ensure that everyone enjoys fair, safe and healthy working conditions and socioeconomic security. Supervision and investigation are the tools used 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 set aside for the Inspectorate at the end of 2017, rising to €50 million in 2022 – a 50% increase compared to 2017. A large part of these extra resources are being used to expand its workforce. As a result, the number of FTEs will grow from around 1,150 in early 2018 to around 1,550 by the end of 2022. Eighty per cent of capacity is allocated to carrying out inspections.

	2016	2017	2018	2019
Expenditure (million €)	103	103	115	131
Number of FTEs	1,149	1,127	1,250	1,355



The Inspectorate is investing heavily in the development of data-driven supervision, particularly when determining which companies or sectors require additional supervision.

With a view to improving efficiency, the Inspectorate is also investing in a stakeholder approach, which involves

extensive consultation with industry bodies and trade unions. In addition, it works with other supervisory authorities. For example, the Inspectorate devotes a great deal of attention to European cooperation by playing an active role in the European Labour Authority (ELA) and the Senior Labour Inspectors' Committee (SLIC), in which all European labour inspectorates are represented. At national level, it collaborates in monitoring the proper handling of hazardous substances, thereby strengthening its working relationship with supervisory authorities in the fields of environmental protection and external safety and security.

Number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered

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 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. The balance between the capacity required to conduct accident investigations and that required to carry out proactive – more preventive – inspections has been disrupted for several years now. To restore this balance to a target ratio of 50:50, 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 (75:25).

Number of breaches of health and safety regulations and the nature and type of sanctions

In 2019 enforcement measures were imposed on 46% of establishments where a health and safety inspection was carried out for the first time. One indicator of the effectiveness of inspections is the enforcement rate at re-inspection. This figure was 16% in 2019, indicating that supervision works.

Sanctions and enforcement instrument

Nearly all breaches of health and safety legislation are sanctionable under administrative law. Exceptions include breaches that result in permanent damage to health or accidents involving fatalities or serious injury, which can be prosecuted under criminal law.

Comment FNV: regarding the breaches: by far most of them, but not virtually all of them.

Comment FNV: various infractions are not sanctioned at all.

If employers or employees break the rules, the SZW Inspectorate takes enforcement action, which may range from warnings to compliance orders and fines. Another enforcement tool at the Inspectorate's disposal is shutting a business down – either immediately, in the event of a manifestly dangerous situation, or preventively, in the event

of repeated breaches.

Comment FNV: only insofar as a sanction has been imposed in violation according to administrative law.

Sanctions are intended to put an end to any breaches of the rules as quickly as possible. Since they can also have significant financial implicatons, the prospect of sanctions can have a preventive effect too.

Comment FNV: however, this is only the case in exceptional cases. Most fines are by no means deterrent.

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.

Comment FNV: and there is no action at all for various violations.

Most of the inspectors of the SZW Inspectorate not only have supervisory authority but 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.

c) *Please indicate whether Inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors. If certain workplaces are excluded, please indicate what arrangements are in place to ensure the supervision of health and safety regulations in such premises.*

In the Netherlands, 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, section 24 of the 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.

d) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been*

remedied. If the previous conclusion was deferred, please reply to the questions raised.

4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

Part I – 11. RESC Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.

The right to protection of health under Article 11 of the Charter complements Articles 2 and 3 of the European Convention on Human Rights; those provisions of international human rights law are closely linked. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Life expectancy (as well as causes of death and infant and maternal mortality) in a community —and life expectancy inequality as might be the case for a sub-group within a community— is a broad indicator for the enjoyment of the right to protection of health and for the delivery by the competent authorities of the measures that enable people to enjoy the highest possible standard of health attainable. There is ample evidence of factors that contribute to or that undermine the health of people.
It is well known that members of certain groups enjoy poorer health and have shorter life expectancy, especially the poor, homeless, jobless or other underprivileged communities and also underprivileged ethnicities. Life expectancy varies from country to country and, in some cases, it varies considerably from one part of the country to another or from one part of the same city to another; reports suggest that the difference in life expectancy can amount to years or even to one decade or more. Life expectancy goes hand in hand with a range of health issues. Children's rights and education are also determinants of future health and life expectancy, as is the family environment (housing, poverty or exclusion, exposure to domestic violence, child abuse or neglect).
Insalubrious work or living environments also affect health adversely as does 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. It is for example a broadly accepted truism that prison is bad for people's health (staff and inmates alike).

As regards health care, it should be available, accessible, acceptable and of sufficient quality (the WHO "3AQ" framework), and informed consent is not only a formal requirement, but it goes to the heart of patient autonomy, self-determination, bodily integrity and well-being. A human rights approach to health requires reliance on

science, excluding ideology or dogmatism. In particular, pseudoscience is a source of risk and, almost invariably, amounts to denial of informed consent; homeopathy in particular can be a drain on public resources or misguide individuals to pointless personal expenditure.

Mental health is an integral part of the right to health. The transition from former large-scale institutions to community-based mental health care was—and, in certain cases, remains—fully justified and desirable. However, reportedly, it was often poorly implemented or insufficient resources were allocated to it. As a result, some persons in need of mental health care were neglected, drifting towards unemployment and poverty, homelessness or petty crime, and ultimately towards prison. Prison administration complain about such cohorts that, in their view, do not belong in the prison system and prison health care services advance that sometimes these inmates represent a high proportion of the prison population.

Under this provision, States Parties must demonstrate their ability to cope with infectious diseases, such as arrangements for reporting and notifying diseases and by taking all the necessary emergency measures in case of epidemics. The latter would include adequate implementation of the measures applied in the COVID-19 crisis: measures to limit the spread of virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.) and measures to treat the ill (sufficient number of hospital beds, including intensive care units and equipment and rapid deployment of sufficient numbers of medical personnel while ensuring that their working conditions are healthy and safe – the latter issue was addressed under Article 3 above). It goes without saying that measures taken in respect of epidemics or pandemics must respect the exigencies of human rights law.

The pandemic did not only place a huge demand on health care services but also revealed in many cases chronic public health underfunding and insufficient capacity to respond to ordinary, let alone extraordinary, needs.

States must operate widely accessible immunisation programmes. They must maintain high coverage rates not only to reduce the incidence of these diseases, but also to neutralise the reservoir of virus and thus achieve the goals set by WHO to eradicate a range of infectious diseases. Vaccine research should be promoted, adequately funded and efficiently coordinated across public and private actors.

Access to health care must be ensured to everyone without discrimination. Groups at particularly high risk such as older persons, the homeless or those poorly housed, the poor and destitute, those living in institutions must be adequately protected by the measures put in place. This implies that health equity as defined by the WHO should be the goal: absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. Ideally, everyone should have a fair opportunity to attain their full health potential and no one should be disadvantaged from achieving this potential. In the medical fields, there is ample evidence of how women have been victims of prejudice and biased science, to the detriment of their health and wellbeing.

Article 11 – The right to protection of health

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

1. to remove as far as possible the causes of ill-health;

a) *Please provide 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.).*

In 2018 overall life expectancy for women was 3.1 years more than for men (83.3 vs 80.2), but women can expect to enjoy fewer healthy life years than men. Women enjoy 1.5 fewer years of perceived good health, 2.3 fewer years with no moderate or severe disabilities, 7.1 fewer years with no chronic disease and 1.1 fewer years of good mental health. Women's greater life expectancy does not therefore equate to more years lived in good health. In other words, disability-free life expectancy (DFLE) was lower for women than for men in 2018: the difference was -4.6 years in terms of self-perceived good health, -5.4 years without disabilities, -10.2 years without chronic disease and -4.2 years without good mental health.
In 2018 life expectancy without chronic disease was 7.1 years higher for men than for women (47.3 vs 40.2 years), whereas with chronic disease 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 disease than men do. Almost three-quarters of the large difference in life expectancy with chronic disease at birth between men and women (10.3 years) is therefore due to the onset of chronic disease before the age of 65. This could be due partly to migraine, which more often affects women and also frequently occurs at a younger age.

Based on purely demographic trends, the absolute number of people with dementia, heart failure or Parkinson's disease will increase most (by 60% or more) in the period 2015-2040. As these occur mainly in elderly people, population ageing leads to an increase in the absolute number of people with these diseases. Conversely, health problems that are less common in the elderly, 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 future trend based on these epidemiological developments has not been quantified.

b) *Please also provide information about sexual and reproductive health-care services for women and girls (including access to abortion services) and include statistical information about early (underage or minor) motherhood, as well as child and maternal mortality. Provide also information on policies designed to remove as far as possible the causes for the anomalies observed (premature death; preventable infection by blood borne diseases; etc.).*

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 through 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), sexual healthcare is also available, anonymously and free of charge, at regional sexual health clinics. During the first few months of the COVID-19 epidemic, access to sexual healthcare via these regional clinics was very restricted due to the fact that the regional health sector was focusing its efforts on fighting the epidemic; access has now resumed, however.

The Netherlands currently has 15 abortion clinics. Abortion care is available freely and free of charge for women living in the Netherlands, without a GP referral. In addition to offering abortion services, the abortion clinics provide information about contraception and preventing unplanned pregnancy.

A total of 31,002 abortions were carried out in 2018, 27,620 of which concerned women living in the Netherlands. In the same year 2,520 of the abortions carried out related to teenage pregnancy, 49 of which involved a girl under the age of 15.
Birth control, and specifically the birth control pill, are an important factor in preventing unplanned pregnancies. The pill is prescribed by a GP and covered through health insurance with a personal contribution.
Comment FNV: the personal contribution for reproductive products forms a barrier for girls and women to purchase contraception. Contraception should be excluded from personal contributions or "*eigen risico*" (own risk).

On 1 January 2019 there were a total of 1,779 teenage mothers. This compares with 1,984 in 2018, indicating a downward trend. The number of children born to girls 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.

c) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.*

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

a) *Please provide 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 (life-long or ongoing) and in schools. Please also provide information about awareness and education in respect of sexual orientation and gender identity (SOGI) and gender violence.*

Sexual and reproductive health education

The Netherlands has launched new initiatives to further reduce unwanted and unplanned pregnancies, such as supporting comprehensive sexuality education tailor-made for different types of secondary education. We also plan to start a multimedia campaign on conscious use of contraceptives and the consequences of unplanned or unwanted pregnancies. In August 2020 a 24/7 hotline was launched where both women and men can get all kinds of information on unplanned and unwanted pregnancies. Lastly, in June 2020 the Dutch government began financing organisations that have specific expertise in supporting women and men to make the right choices in their particular situation in the event of an unwanted or unplanned pregnancy.

Attainment targets are applicable in primary and secondary education and indicate what schools should include in their curriculum (but not how they do so). Schools are free to determine how these are implemented. The attainment targets in relation to sexuality and sexual diversity now cover 'learning to respect sexuality and diversity within society, including sexual diversity'. The most common teaching methods also consider sexually inappropriate behaviour, such as unwanted sexting.

The attainment targets are shortly due to be reviewed, with the aim of providing schools and teachers with a clearer framework with which education on sexuality, sexual resilience and sexual and gender diversity must comply. Teams of teachers have taken the lead in this exercise. The further details will also be worked out with teachers, educationalists and schools.

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

b) *Provide information on measures to ensure informed consent to health-related interventions or treatment and on specific measures to combat pseudoscience in respect of health issues.*

In the Netherlands, the legal guarantee that people receive sufficient information before consenting to health-

related interventions or treatment (i.e. the right to informed consent) is enshrined in the Medical Treatment Contracts Act. Since 1 January 2020 this statutory right has been supplemented by a number of safeguards to promote proper consultation between health professionals and patients about the various treatment options available, including those offered by other care providers. As a result, patients are better able to have a real exchange of views with health professionals and jointly decide on a particular course of treatment. The important thing is that the patient, together with the care provider, can come to the best possible decision about the treatment that the patient considers appropriate for their situation. Patient involvement in decision-making is a further interpretation of the right to self-determination under Article 8 of the European Convention on Human Rights. This amendment of the Medical Treatment Contracts Act is part of a broader approach to promote patient involvement in healthcare decision-making in the Netherlands. The government and the medical profession are working on this together. Joint decision-making based on relevant information enables patients to reach more informed decisions about possible treatment options. This calls for a cultural change in the healthcare sector. The emphasis in patient-doctor conversations will be more on what the patient needs in life. This cultural change is already underway and, in addition to the aforementioned legislative amendment, is supported by agreements, measures and programmes drawn up by the medical profession and the government.

The legal guarantee that all patients receive proper care is laid down in the Healthcare Quality, Complaints and Disputes Act, which is intended to safeguard the quality of care and prevent risks to patients. Under this legislation, all care providers are required to provide proper care, which is defined as care that is of good quality and of a good standard and that is delivered safely, timely and tailored to the patient's actual needs. Patients' rights must be scrupulously respected. Proper care is provided when care workers act in accordance with their responsibilities, based on professional and quality standards.

c) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.*

3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

a) *Please describe the measure taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.*

The Ministry of Health, Welfare and Sport has tasked the National Institute for Public Health and the Environment (RIVM) with contributing to greater scientific understanding in the field of immunology and to vaccine development. In addition, RIVM is tasked with purchasing vaccines for the national vaccination programme. This also includes managing the associated network of public and private stakeholders. Furthermore, vaccine institute Intravacc now falls under the Ministry of Health, Welfare and Sport. Intravacc has an important role in fostering public-private

partnerships. This is a source of some tension, however, which may eventually lead to Intravacc being privatised.

b) Please provide a general overview health care 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.).

Mental health facilities at detention centres and prisons provide care for people with a wide range of mental health issues. In some cases, psychiatric problems may cause individuals to behave in such a way that the risk they pose to themselves, other patients or mental health professionals is so great that routine clinical admission is not a sufficiently safe option. If so, the practitioner may decide to provide more intensive care by transferring a patient to a more secure facility at a psychiatric hospital. The options available, depending on the patient's condition, are:

- A forensic psychiatric ward, where staff are trained to deal with patients exhibiting dangerous or aggressive behaviour as a result of their psychological disorder. The level of security is higher than in a secure ward; the hospital facility is fenced and freedom of movement is somewhat restricted.
- A second option is a forensic psychiatric clinic. Here, the level of security is considerably higher than in a forensic psychiatric ward; in particular, access to the clinic is more secure and freedom of movement is more restricted. Staff are trained to deal with more severe cases.
- In exceptional cases, a patient may be placed in a forensic psychiatric centre, which is regarded as a last resort for patients who have not committed any criminal offence. This facility has the highest level of security. In cases where medical staff cannot approach a patient to provide treatment, they are supported by security personnel.

In principle, admission to one of these facilities is temporary. Patients can return to a regular clinical mental health setting once their condition has stabilised. They are placed in this facility under a compulsory care order issued under the Compulsory Mental Healthcare Act.

Responsibility

The governor of the prison or detention centre is responsible for the day-to-day running of the institution, including organising the medical care provided.

Human and other resources

Each institution has its own medical service, comprising nurses, doctors (GPs) and administrative support staff. Doctors make diagnoses and decide whether care is necessary and urgent. Doctors can also refers patients to a hospital or an in-house or external physiotherapist, psychologist, psychiatrist or dentist. The institution's psycho-medical team in any case consists of the mental health nurse or nurses, the institution's doctor, the psychologist or psychologists and the psychiatrist working in the relevant ward. The team convenes weekly for a psycho-medical consultation meeting. The chair (usually the psychologist) coordinates care for each inmate and on the ward. The

team strives to stabilise and/or improve psycho-medical problems by putting together a care plan and coordinating the individual contributions of the various team members to that plan, as well as liaising with any external care providers.

Practical rules

In order to establish professional frameworks, guidelines, training and quality assurance, the Custodial Institutions Agency (*Dienst Justitiële Inrichtingen*) has brought together its care-related expertise within the Netherlands Institute of Forensic Psychiatry and Psychology (*Nederlands instituut Forensische Psychiatrie*). The tasks of this national service include formulating process descriptions, quality standards, guidelines and protocols, as well as providing training and guidance for healthcare professionals.

Medical screening upon arrival

Each detainee has a medical intake assessment within 24 hours of arrival. All institutions provide 24-hour GP care.

Access to specialist care

The Custodial Institutions Agency provides detainees with essential medical care that cannot be postponed and that is of comparable quality to care provided in the regular healthcare system in accordance with the Healthcare Quality, Complaints and Disputes Act. In principle, the package of medical care delivered by the Custodial Institutions Agency is aligned with the basic package set out in the Health Insurance Act, taking into account the special requirements and restrictions that may result from detention. This includes ordinary medical care provided by GPs, municipal health service doctors, and consultants, including the related examinations, as well as by specialists affiliated with an independent treatment centre. A medical practitioner (the institutional doctor, psychiatrist or dentist) initially determines the necessity and urgency of commencing a particular treatment. Treatments that had already started outside the custodial setting will, in principle, be continued, unless a medical practitioner at the institution decides otherwise. Detainees requiring clinical psychiatric care can be referred to the custodial psychiatric centre.

Prevention of communicable diseases

The Custodial Institutions Agency's policy aims to prevent, track and treat infectious diseases, by:

- providing information, especially to high-risk detainees;
- taking protective measures;
- identifying high-risk behaviour during intake;
- carrying out examinations, if necessary, if high-risk behaviour is identified;
- providing proper medical and psychosocial care to detainees who may have an infectious disease;
- conducting contact tracing among fellow detainees and staff.

An outbreak management working group was formed in 2016 with the task of giving early warning of possible outbreaks of infectious diseases. To this end, it monitors reports issued by WHO and RIVM. The working group also

disseminates advice on preventive measures, for example, through information leaflets.

Mental healthcare provision

The Netherlands Institute of Forensic Psychiatry and Psychology is responsible for both psychological and psychiatric care in detention. Each custodial institution has access to a psychologist and a psychiatrist and, if necessary, detainees can also be admitted to a custodial psychiatric centre, where anyone with a severe mental disorder will receive specialised care. Custodial psychiatric centres are part of a regular custodial institution, but have their own regime. Treatment in these centres focuses on stabilisation and recovery and supports reintegration. It is delivered by a multidisciplinary team comprising registered general psychologists, psychiatrists, doctors and mental health nurses/nurse practitioners. Custodial institution wards are staffed by personnel with special training in care and treatment in custodial settings.

During the execution of a sentence or order, forensic care can also be provided outside the custodial setting. This includes mental healthcare, addiction treatment and/or care for detainees with intellectual disabilities, as part of a sentence or order (suspended or otherwise) or the execution thereof (during detention), or as part of another sanction under criminal law. Based on a needs assessment to identify both an individual's care needs and the required level of security, a decision is made on where the individual can best receive forensic care. This may also mean transferring the person concerned to a regular care institution.

c) *Please provide information on the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. Please provide statistical information on outreach measures in connection with the mental health assessment of vulnerable populations, including those in a situation of poverty or exclusion, the unemployed (especially long-term unemployed). Provide also information on proactive measures adopted to ensure that persons in need of mental health care are not neglected. Please also provide information from prison health- care services on the proportion of inmates who are deemed as having mental health problems and who, according to health-care professionals, do not belong in the prison system or would have possibly been spared of such a situation should suitable mental health services been available to them in the community or in specialised establishments.*

In the case of people who are not fit to be detained, or who do not belong in the prison system for some other reason related to their mental condition, Dutch regulations and practical implementation measures are aimed at preventing them from entering or remaining in detention.

The mental state of the individual concerned is therefore taken into account at various points in the criminal proceedings. For instance, the public prosecutor may decide to drop a case because of the accused's mental state or

the court may decide to suspend the legal proceedings or hearing. The individual's mental state is also taken into consideration when passing sentence. If it so warrants, the court may, instead of handing down a custodial sentence, impose a hospital order or other form of forensic care. The criminal court also has the power to impose a compulsory care order instead of a custodial sentence or criminal penalty (section 2.3 of the Forensic Care Act). The care order may involve either compulsory admission to a healthcare institution or compulsory care as an outpatient.

As previously mentioned, anyone sentenced to a term of imprisonment will undergo a medical intake assessment on arrival in detention. Very occasionally, the fact that someone is not fit to be detained only emerges during intake. In this case, it may be decided to defer execution of the sentence (temporary unfitness for detention) or there may be grounds for granting a pardon (expected permanent unfitness for detention). Furthermore, as explained above, mental healthcare is provided in detention and any inmates with a mental disorder can be transferred to a care institution.
Commissioned by the Association of Netherlands Municipalities and the Ministry of Health, Welfare and Sport, the consulting firm KPMG Nederland is investigating the relationship between outreach measures and the mental health assessment of vulnerable groups. A survey will be conducted starting in 2021.

d) Please also provide 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. Provide 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, which 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).

e) Please provide information on 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 measures taken to address health problems of the populations affected. Please provide also information about measures taken to inform the public, including pupils and students, about general and local environmental problems.

In the Netherlands, we have made great strides with our environmental policy over the past few decades and have achieved some success. At the same time, we are still contending with persistent problems and new ones are

emerging. This calls for further reflection on our approach to environmental standards, the trade-off between short-term and long-term interests, the trend towards outsourcing environmental problems to other countries or to future generations, the leading role of central government, the permitting system, supervision and enforcement, and the fragile support among the general public and businesses for measures to improve the environment.

Stronger role for government

The government will play a stronger role in the social transitions necessary to achieve true sustainability, for example by using a good mix of policy instruments to provide frameworks and help consumers and producers. Since the turn of the century, government policy has focused on incentives for pioneers, including through voluntary agreements between public authorities and private-sector parties and Green Deals. The more binding instrument of laying down mandatory standards has been given less emphasis.

The government's leading role also needs to be strengthened by modernising statutory instruments, and the introduction of the Environment and Planning Act is an important step in the right direction. The scope for updating the Environmental Management Act will be explored and its consistency with related environmental legislation evaluated. In addition, options for ensuring that environmental principles and basic premises are enshrined in law will be re-examined.

Inspired by existing and internationally widely accepted environmental principles, four key areas for improvement have been identified:

1. **Greater focus on preventing environmental losses, whether due to pollution, depletion or other causes.** This concerns prevention as part of chemical substances policy and in relation to processes and products, for example by applying the precautionary principle more strictly when assessing and authorising new chemicals. It also includes investing in knowledge and innovation (sustainability, waste prevention and product recycling) and applying the 'Safe by Design' principle (social function is adapted to physical conditions such as the water table and environmental constraints). Another aspect is stimulating the circular economy (fewer raw materials and more efficient products and services). Central government's role will be strengthened through, for example, a more binding set of instruments for setting standards and achieving a sustainable economy, and promoting the use of pricing and regulation. Collaboration with local, regional and provincial government will also be enhanced. All these initiatives should lead to modernisation of the Environmental Management Act.
2. **Managing the risks of outsourcing environmental problems.** This involves taking environmental damage into account in the price of raw materials and products or increasingly using financial and legal incentives over the next few years to discourage the disposal and incineration of waste and encourage the recycling and reuse of raw materials with a view to achieving a circular economy (at national and local level). This includes producer responsibility agreements. There is also a risk of shifting problems between environmental themes, for example energy transition or water treatment producing clean water and dirty sludge. Ex ante environmental impact assessments will therefore be carried out.
3. **Continuous improvement of environmental quality in relation to existing environmental issues;**

for example, (1) the Clean Air Agreement (where progressive standard-setting is one of the possible instruments and a driver for innovation), (2) the Aviation Agreement (airport expansion, which is important for competitiveness, is only possible if it can be done in a way that is demonstrably safe, and leads to a clear reduction in nuisance levels and a better quality of the physical environment), and (3) soil quality policy.

4. **Contact and collaboration, both at home and abroad, with other government bodies, businesses, NGOs, scientists and the general public.** In contrast to policy in previous years, the aim is to focus increasingly on preventing, rather than remedying, environmental problems. Existing monitoring programmes will provide invaluable data (earth observation, air quality and citizen science, where the public is actively involved in monitoring the quality of the physical environment). Debates on environmental issues will also be organised, and public campaigns (for example on fuel-efficient driving) continued.

f) In the context of the COVID-19 crisis, please evaluate the adequacy of measures taken to limit the spread of virus in the population (testing and tracing, physical distancing and self- isolation, provision of surgical masks, disinfectant, etc.) as well as the 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 while ensuring that their working conditions are healthy and safe – an issue addressed under Article 3 above). Please indicate the measures taken or foreseen as a result of this evaluation.

The Netherlands' response to COVID-19 focuses on three key aspects. First, protecting vulnerable groups in society; second, relieving the pressure on our healthcare system; and third, monitoring the spread of the virus. To protect vulnerable groups and relieve pressure on the healthcare system, the following measures have been put in place: COVID-19 testing and mandatory self-isolation for anyone presenting with symptoms, mandatory physical distancing and restrictions on gatherings. In addition, people are encouraged to work from home, follow rules for personal hygiene and avoid busy places. Non-medical face masks must be worn on public transport and in designated areas at airports. Everyone over the age of 13 is strongly advised to wear a non-medical face mask in indoor public spaces, such as shops and museums.

In The Netherlands anyone with symptoms can make an appointment for a COVID-19 test. If the test is positive, the municipal health service (GGD) carries out contact tracing. At the moment, healthcare workers and teachers are prioritised for COVID-19 testing.

To monitor the spread of the virus, the Netherlands has implemented a monitoring system called the 'Coronavirus dashboard', which shows the latest national, regional and local information on infection rates, hospital admissions, etc.. The dashboard can serve as an early warning tool to indicate when additional measures are necessary to control the spread of COVID-19 in a specific region.

The Netherlands has several measures in place to ensure that sufficient medical devices, medical personnel, hospital capacity and PPE are available. For PPE and medical devices, the Netherlands strives to maintain an emergency stock so as to be able to respond to sudden increases in demand. At the start of the pandemic, the Netherlands set up a national centre for acquiring medical devices and distributing them evenly around the country. To ensure sufficient medical personnel, hospitals can make use of temporary staff who can apply or volunteer online (www.extrahandenvoordezorg.nl). 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.

ICU capacity is to be increased on 1 October 2020 from 1,150 to 1,350 beds. At the same time, capacity for COVID-19 patients in nursing wards will be increased by 400 beds. A flexible ICU capacity of 1,700 beds and an additional 700 beds in wards should be available by 1 January 2021. Thanks to these measures, we expect to be able to cope with a new wave of COVID-19 patients and are trying to avoid having to scale down regular healthcare.

The above is a summary of the measures in place to control the spread of coronavirus and treat anyone who is ill. A full evaluation of the effectiveness of these measures is planned in the near future.

g) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.*

In order to satisfy the needs of a community, social security must be enabled to cover a range of minimum benefits and the system must be sufficiently funded in order to do so. The European Code of Social Security provides that the cost shall be borne collectively by way of insurance contributions or taxation or both, in a manner which avoids hardship to persons of small means and takes account of needs and of the economic situation of the country concerned. It also indicates that the part of the burden borne by employees should not exceed 50 per cent of the total of the financial resources allocated to their and their relatives protection.

Article 12 of the Charter requires that the social security system be at least of the level necessary under the European Code of Social Security.

While issues of sustainability and the situation of the economy are relevant, so are questions of progressive realisation of human dignity, which is at the heart of human rights (including social rights). Financial consolidation is therefore not in itself a decisive factor, given that resource availability and allocation are subject to political determination. According to various sources, public social spending amounts to just over 20% of GDP on average across Europe (c. 28% for the European Union), with around 60% of the expenditure on average being cash benefits and 40% health and social services.

Article 12 – The right to social security

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

1. to establish or maintain a system of social security;

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

2. to maintain the social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;

3. to endeavour to raise progressively the system of social security to a higher level;

a) *Please provide information on social security coverage and its modalities provided to persons employed or whose work is managed through digital platforms (e.g. cycle delivery services).*

The type of contract under which people carry out work determines the social security coverage of those who are employed via digital platforms (for example bicycle delivery services). If they work for a digital platform under an employment contract, they are covered by national insurance in the event of unemployment (Unemployment Insurance Act), illness (Sickness Benefits Act) and/or disability (Work and Income (Capacity for Work) Act). If they are self-employed, they are not automatically insured against unemployment, sickness and/or incapacity for work, and must take out private insurance against these risks themselves. If necessary, they can claim social assistance benefit under the Participation Act, which is a minimum income benefit, subject to certain conditions.

Comment FNV: There is a problem with people working as a domestic worker (Under Regulation of domestic services). They are excluded by national law from some forms of social security, such as unemployment (WW) of sick pay after six weeks of illness. Especially the lack of unemployment benefits have left this group of workers extremely vulnerable during the lockdown.

National insurance provides benefits amounting to 70% of the last-earned wage for at least three months and up to two years in the event of unemployment. To be eligible, the individual must have worked for at least 26 weeks as a salaried employee in the 36-week period prior to the onset of unemployment. If the beneficiary does not have a new job after termination of the benefit, they can claim social assistance benefit under the Participation Act, which

is a minimum income benefit, subject to certain conditions. In the event of illness, salaried employees are entitled to continued payment of their salary for 104 weeks. If the employment contract ends before this, 70% of the last-earned wage will be paid under the Sickness Benefits Act, provided that the employee in question is no longer able to work in their own occupation (during the first year of illness) or in a suitable alternative occupation (during the second year). This benefit is provided for a maximum of 104 weeks, counting from the first day of illness. An employee who is unable to earn at least 35% of the last wage earned through suitable work for a period of more than 104 weeks due to illness or disability is entitled to disability benefit. This benefit amounts to 70% of the last-earned wage for at least three months and at most two years, depending on the employee's length of service. After this period the benefit is calculated according to the degree of invalidity. This benefit is paid until the beneficiary's medical or income situation improves such that they can earn enough to support themselves, or until they reach state pension age.

b) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.*

c) *Please provide information on any impact of the COVID-19 crisis on social security coverage and on any specific measures taken to compensate or alleviate possible negative impact.*

Under the Temporary Emergency Scheme for Job Retention (*Noodmaatregel Overbrugging voor Behoud van Werkgelegenheid*, NOW), the government pays up to 90% of the wage costs of companies that have been affected by the COVID-19 crisis. The first tranche of NOW ran from 1 March to 1 June and the second runs from 1 June to 1 October. The scheme allows companies to retain their employees so that they do not need to apply for regular social security.

Despite the NOW scheme, people have lost their jobs. In that case, they can apply for standard unemployment or social assistance benefit if they meet the conditions. The Temporary Bridging Scheme for Flexible Workers (*Tijdelijke Overbruggingsregeling voor Flexibele Arbeidskrachten*, TOFA) has been created for flexible workers who are not eligible for either unemployment benefit (for example because they have only been employed for a short time) or social assistance benefit (for example because of their partner's income). Under the TOFA scheme, flexible workers were entitled to a one-off payment of €550 per month for the months of March, April and May. To be eligible, they must have earned a minimum of €400 in February and no more than €550 in April.

4. to take steps, by the conclusion of appropriate bilateral and multilateral agreements or by other means, and subject to the conditions laid down in such agreements, in order to ensure:

a. equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;

b. the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties.

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

Part I – 13. RESC Anyone without adequate resources has the right to social and medical assistance.

A state will only meet its commitments under Article 13 of the Charter if —or when— it secures the effective exercise of the right to social and medical assistance to everyone who is without adequate resources and who is unable to secure such resources either by their own efforts or from other sources, in particular by benefits under a social security.

Because this right concerns persons in a situation of great need and enhanced vulnerability, it is incumbent upon States Parties to ensure that there are no unreasonable obstacles or insurmountable hurdles to the exercise of the right. As the Committee indicated in European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 151/2017, decision on the merits of 5 December 2018, §84, while there may be avenues available to people to assert their rights, this ability "cannot be assumed for people whose degree of exclusion, past experience and social status places them in a situation where they may not have the means" of exercising their rights. "In such cases, the authorities have a responsibility to support the persons concerned in order to overcome the barriers so that they can effectively assert their rights. Failing such a proactive approach on the part of the Government, the rights and remedies are rendered illusory for the disadvantaged communities in question. This is all the more relevant and important when fundamental rights are concerned, especially the right to health and the conditions under which the enjoyment of that right is enabled."

Article 13 – The right to social and medical assistance

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

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

a) *Please describe any reforms to the general legal framework. Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.*

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 new legislation is 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. On 1 January 2019 the net benefit for people older than 20 and younger than state pension age, depending on age and situation, was as follows:

Married/cohabiting couples	
Per month	€1,391.82
Holiday allowance	€73.25
Total	€1,465.07
Single people and lone parents	
Per month	€974.27
Holiday allowance	€51.28

Total	€1,025.55

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. 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.

The poverty threshold in the Netherlands, defined by Eurostat as 50% of the median equivalent income, was €12,246 in 2019 for a single person, and €25,716 for a couple with minor children. Supplements and municipal schemes are not included in this definition.

People under state pension age receiving social assistance benefit

	Total no. of people
January 2016	464,500
January 2017	456,830
January 2018	432,460
January 2019	414,620

Source: Statistics Netherlands (CBS)

b) Please indicate any specific measures taken to ensure social and medical assistance for persons without resources in the context of a pandemic such as the COVID-19 crisis. Please also provide information on the extent and modalities in which social and medical assistance was provided to people without a residence or other status allowing them to reside lawfully in your country's territory.

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.

c) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

Part I – 14. RESC Everyone has the right to benefit from social welfare services.

Many of the introductory comments made for Articles 12 and 13 are also relevant to the right to benefit from social welfare services. It is nonetheless worth stressing the requirement of universality; the right to benefit from social welfare services must potentially apply to the whole population, which distinguishes the right guaranteed by Article 14 from "the various articles of the Charter which require States Parties to provide social welfare services with a narrowly specialised objective".

The provision of social welfare services concerns everybody who find themselves in a situation of dependency, in particular the vulnerable groups and individuals who have a social problem. Social services must therefore be available to all categories of the population who are likely to need them. The Committee has identified the following groups: children, the elderly, people with disabilities, young people in difficulty or in conflict with the law, minorities (migrants, Roma, refugees, etc.), the homeless, persons suffering from substance use disorders, women victims of violence and persons in conflict with the law, including those deprived of their liberty and former detainees. This is not, however an exhaustive enumeration of persons entitled to access and benefit from social welfare

services.

The state has an obligation to take every appropriate measure to ensure that no one is left behind. Therefore it is required to implement apposite outreach arrangements. Meeting this obligation will often require proactive service-oriented action, with the competent authorities taking the initiative rather than merely responding to applications and requests. It should be recalled that fundamental rights are mirrored by fundamental obligations for the duty bearers.

a) *Please explain how and to what extent the operation of social services has been maintained during the COVID-19 crisis and whether specific measures have been taken in view of possible future such crises.*

Chronic care – care providers and health professionals

The Dutch government's policy on chronic care (including the Social Support Act, the Chronic Care Act and the Youth Care Act) aims 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. As a result of the pandemic, chronic care has come under great pressure. Shortly after the outbreak of the virus, the government therefore announced that it wished to reassure care providers that it would do its utmost to mitigate the financial implications of the COVID-19 crisis so that health professionals could concentrate on delivering the necessary care safely.

The measures address the financial problems facing care providers as a result of the COVID-19 pandemic. These include, on the one hand, higher costs due to, for example, increased use of PPE or other material and staff costs and, on the other hand, ongoing costs of care providers faced with lower revenue due to a decline in the occupancy rate or because day centres have to be closed.

The measures respond to these financial problems. Arrangements have been put in place to compensate care providers impacted by COVID-19, in part for the additional expenses they are incurring and in part for any drop in demand they are experiencing.

The measures taken are temporary: the situation will be monitored to see how the COVID-19 crisis develops, whether the support is still needed and whether the measures need to be extended. At the time of writing (September 2020), the arrangements apply until 31 December 2020.

People with disabilities or chronic disease

A COVID-19 strategy for people with disabilities and/or underlying health problems (such as a chronic disease) has recently been developed. 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.

This strategy includes the following elements:

- Representatives from central and local government and providers of care and support under the Social Support Act came together at the start of the spring lockdown to discuss how to guarantee continuity of care and support for as long as possible for people in vulnerable groups living at home. This resulted in agreements on existing and additional funds and payments, as well as guidelines on household help, daytime activities and day care, provision of medical devices, and informal care. Together, they constitute the government's approach to vulnerable people living at home and their informal carers in the event of crisis situations and health complications.
- A road map for lifting restrictions for people with health issues has been produced. This includes steps that will benefit people with disabilities, such as continuing day care and transportation.[3]
- A great effort has been made to ensure that any information provided is accessible and easy to understand. Examples include the use of sign language interpreters, transcriptions of debates, comprehensible summaries and the launch of the information website Steffie.nl.
- The strategy for people with disabilities is being monitored.
- In the various protocols on social distancing, attention is specifically drawn to the situation of people with disabilities and/or health issues. This also applies to the testing policy and protective equipment.

Youth care

- Since the start of the COVID-19 crisis, the basic principle has always been to continue to provide youth care services wherever possible. During the early stages of the outbreak, care providers sometimes had to offer these services in an alternative form as a result of coronavirus measures (implemented from mid-March 2020 onwards). The Ministry of Health, Welfare and Sport liaised closely with the entire care sector on this matter, holding a meeting with all relevant stakeholders every other day. The Ministry also helped draw 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.

[3] https://www.rijksoverheid.nl/documenten/publicaties/2020/05/20/routekaart-voor-mensen-met-een-kwetsbare-gezondheid

- The Health and Youth Care Inspectorate has been in daily contact with youth care providers during the crisis to enquire about the impact of the pandemic on the quality and safety of youth care and on the situation for young people in youth care. This shows that, since mid-May 2020, regular youth care services, such as day centres, respite care, home visits and face-to-face contact, have resumed.
- At the moment, we cannot say for sure what impact the COVID-19 crisis has had on youth care uptake. On 30 October 2020 Statistics Netherlands (CBS) is due to publish the half-yearly figures for youth care in 2020. Initial quick scans by the Youth Authority reveal that, generally speaking, youth care providers were better able to provide youth care that was needed, but that they nevertheless delivered less than normal.
- The Ministry of Health, Welfare and Sport continues to consult with the youth sector ahead of a second wave of infections. Youth care providers are learning lessons from the first wave to ensure continuity of care.

b) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

a) Please 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 and in the design and practical realisation of services. Co-production is here understood as social services working together with persons who use the services on the basis of key principles, such as equality, diversity, access and reciprocity.

Participation legislation

The Netherlands has a new Care Institutions (Patient Participation) Act 2018,[4] replacing the existing but outdated act. The objectives are to strengthen the position of patients and promote good governance in

[4] The Care Institutions (Patient Participation) Act 2018 came into effect on 1 July 2020 https://zoek.officielebekendmakingen.nl/stb-2019-215.html.

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. The Act succeeds in its aim of strengthening the position of patients by giving patient councils 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.

People with disabilities and chronic disease

Input has been received from various parties and experts, including patient organisations, on the lessons learned during the first wave of the COVID-19 pandemic. These are important not only to prepare for a possible second wave but also to ensure that people with disabilities or chronic disease can participate in society on an equal footing.

The lessons learned:

1. Communicate information in a clear and accessible manner
2. Involve patients and their families
3. Strike a balance between safety and quality of life
4. Strengthen national and regional positioning
5. Ensure sufficient staff and take care of their well-being
6. Ensure adequate personal protective equipment and testing
7. Improve monitoring, detection and intervention
8. Ensure continuity and support
9. Develop and share knowledge and expertise

The lessons learned are the fruits of our experience over the past few months and point the way forward.

Youth care

One important aim of the Youth Act (2015) is 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

as partners (*Kennisnetwerk jeugd en ouders als partners*) has produced a guide for municipalities.
In addition, 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.

b) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised*

Part I – 23. RECS Every elderly person has the right to social protection.

This Article seeks to ensure that older people are recognised and treated as full members of society, both in law and in fact. It allows to examine other provisions of the Charter (e.g. Article 11 on the right to protection of health; Article 12 on the right to social security; Article 13 on the right to social and medical assistance; Article 30 on the right to protection against poverty and social exclusion; and Article 31 on the right to housing). As time passes, older people increasingly become dependent and, as their ability to defend themselves and to assert their rights weakens, they become growingly vulnerable. There have been many examples following the 2008 economic downturn of the resources available being progressively shifted away from older people towards other perceived priorities, with scarce pushback from society and, less surprisingly, from those most affected by the budget cuts and subjected to increased dependency and vulnerability.

A range of issues are covered under Article 23, from discrimination and decision making to accessibility, participation (political life, culture, education) and adequate pensions (whether contributory or non-contributory, and other complementary cash benefits available). It would be contrary to the Charter to allow the situation of older people to deteriorate progressively leading

them into —rather than drawing them out of— poverty. Ensuring access to rights requires the provision of information about rights, services and facilities. But, as under other Articles of the Charter, effectiveness may well require outreach and a proactive approach from the authorities.

Supervision and inspection services may be key to ensuring delivery against the requirements of this Article.

Article 23 – The right of elderly persons to social protection

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

– to enable elderly persons to remain full members of society for as long as possible, by means of:
a. adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
b. provision of information about services and facilities available for elderly persons and their opportunities to make use of them;

– to enable elderly persons to choose their lifestyle freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:
a. provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
b. the health care and the services necessitated by their state;

– to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

a) *Please provide detailed information on measures (legal, practical and proactive, including as regards supervision and inspection) taken to ensure that no older person is left behind in terms of access to and enjoyment of their social and economic rights.*

The Dutch pension system is a three-tier system. The first tier (state pension paid under the General Old Age Pensions Act, abbreviated to AOW) is a general social insurance scheme for all residents of the Netherlands, including those who are self-employed. The second tier is made up of pension funds for employees only (although there are some exceptional situations in which self-employed persons are eligible for second-tier pensions). The self-employed can also participate in the third, voluntary tier (private pension arrangements).

The AOW state pension is financed through income-based contributions and from the country's treasury. The scheme provides flat-rate pensions with rates depending on the household situation. All residents of the Netherlands below the statutory retirement age are insured for a state pension. Anyone below the statutory retirement age who works in the Netherlands and pays tax on earned income is also insured. A

person is entitled to a full AOW state pension after being continuously insured for the 50 years before statutory retirement age. For every year not spent living or working in the Netherlands, the pension is reduced by 2%. The statutory retirement age in 2020 is 66 years and four months.

b) *Please provide information on specific measures taken to protect the health and well-being of the elderly, both in their home and in institutional settings, in the context of a pandemic crisis such as the COVID-19 crisis.*

To protect the elderly 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. At the time of writing, visitors are allowed again and no restrictions are in place, except in homes where one or more cases of COVID-19 have been confirmed, in which case it is prohibited to visit the home without the manager's permission.

Another important aspect concerns the guidelines produced by the National Institute for Public Health and the Environment (RIVM) regarding the use of PPE by care workers and the testing policy for patients and care workers. For example, where the virus is more prevalent in the vicinity of a care home, random testing is carried out. These guidelines also help protect the health of elderly people.

Specialists in geriatrics have drawn up treatment guidelines, setting out the correct diagnosis, prevention and treatment of residents with COVID-19, including medically isolating infected individuals (cohorting).

The infrastructure of municipalities has been crucial during the COVID-19 pandemic to ensure that appropriate care and support can be provided to residents and that warning signs can be picked up early. The neighbourhood social support teams and the 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 participate in society in a way that suits them.

c) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised*

Part I – 30. RESC Everyone has the right to protection against poverty and social exclusion. RESC

Living in a situation of poverty and social exclusion violates the dignity of human beings. Living at risk of falling into poverty and exclusion is damaging for the person, not only as regards dignity, but it also entails suffering, loss in cognitive function and social abilities. Risk of poverty and actual poverty and exclusion also compromise the exercise of a range of other rights, both social and economic (employment, health, education, housing, etc.) and civil and political rights (private and family life, association and opinion) and ultimately involves total disenfranchisement. Leaving no one behind and protection against poverty and social exclusion are not just a question of statistics but are a primary human rights requirement, universal in scope, and it is therefore a matter of priority and of resources.

The main indicator used to measure poverty is the relative poverty rate. The at-risk-of-poverty rate before and after social transfers (cf. Eurostat) is used as an indicative value to assess national situations, without prejudice to the use of other suitable parameters that are taken into account by national anti-poverty strategies or plans (e.g. indicators relating to the fight against the 'feminization' of poverty, the multidimensional phenomena of poverty and social exclusion, the extent of 'inherited' poverty, etc.).

The Committee wishes to emphasise the very close link between the effectiveness of the right recognized by Article 30 of the Charter and the enjoyment of the rights recognized by other provisions, such as the right to work (Article 1), access to health care (Article 11), social security allowances (Article 12), social and medical assistance (Article 13), the benefit from social welfare services (Article 14), the rights of persons with disabilities (Article 15), the social, legal and economic protection of the family (Article 16) as well as of children and young persons (Article 17), right to equal opportunities and equal treatment in employment and occupation without sex discrimination (Article 20), the rights of the elderly (Article 23) or the right to housing (Article 31), while recalling the important impact of the non-discrimination clause (Article E), which includes non-discrimination on grounds of poverty.

Extreme poverty—i.e. people living in severe deprivation, without enough food or even suffering

from malnutrition, poorly housed, homeless or with no access to shelter, and without access to clean water and sanitation, etc.—has not yet been eradicated throughout Europe. Extreme poverty does not only affect individuals but also vulnerable communities. Because of their state and status, they are sometimes left out from official statistics. They are among the furthest behind in respect of whom the United Nations Sustainable Development Goals and the Agenda 2030 (that has been adhered to by all Council of Europe member States) calls for priority action.

Article 30 – The right to protection against poverty and social exclusion

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

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

b. to review these measures with a view to their adaptation if necessary.

a) Please provide detailed information on measures (legal, practical and proactive, including as regards supervision and inspection) taken to ensure that no person drops under the poverty threshold, and provide also information on the impact of the measures taken. Please indicate how many people in your country are at risk of poverty, how many in a situation of poverty, and how many in extreme poverty, including specific data for children.

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, since work (or more hours of work) is the best way out of poverty.
2. Income policy: focusing on the purchasing power of people with low incomes and ensuring that work pays.
3. Income guarantee policy: guaranteeing that everyone can rely on a minimum income.
4. Child poverty policy: promoting the social participation of every child in a low-income family and reducing the number of children growing up in poverty.

Two important initiatives are the Comprehensive Approach to Tackling Debt *(Brede Schuldenaanpak)* and Child Poverty Ambitions *(Ambities Kinderarmoede)*. Together with municipalities, implementing organisations and civil society organisations, the government has been working on rolling out the Action

Plan on a Comprehensive Approach to Tackling Debt since 2018, which includes more than 40 measures to tackle debt problems.

In 2019 the government formulated four ambitions to further reduce child poverty:

1. Every child growing up in a low-income family can participate socially. In 2021, 100% of children whose parents claim social assistance benefit and 70% of children from working families on low incomes will be reached.
2. The number of low-income households with children will show a downward trend over the next few years.
3. There will be regular reviews of social exclusion among children.
4. There will be regular reviews of good practices and initiatives by municipalities and other local and national organisations, aimed at preventing child poverty and its adverse effects on children.

Various measures are being implemented to achieve these ambitions.

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

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

Position of the Netherlands by indicator, 2019

Indicator	At-risk-of-poverty rate	Severe material deprivation	Jobless households
% of the population	13.2	2.4	9.0

(Source: Eurostat)

The Netherlands scores better than average on the 'at-risk-of-poverty' indicator. This has to do with the relatively high minimum wage and comprehensive social security system. The Netherlands also scores well on the material deprivation indicator. Municipalities are able to provide special assistance to anyone

suffering material deprivation. A relatively high proportion of people have a low work intensity (jobless households), though their income is not below 60% of the median (at risk of poverty).

A total of 16.5% of the population of the Netherlands (2019) fall within the EU poverty criterion (at risk of poverty and social exclusion); 15.3% of children under the age of 16 are at risk of poverty or social exclusion.

b) Please provide information on measures taken to assist persons affected by poverty, social exclusion and homelessness during the COVID-19 crisis, or after the crisis to mitigate its effects.

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 an additional package of social measures within the broad support and recovery package,[5] the government is setting aside about €1.4 billion for the period 2020-2022 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. A total of €150 million will be made available to combat poverty and problem debt.

In the Netherlands, 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[6] calling on municipalities to take additional measures to organise services for homeless people in line with the national guidelines for combating the virus. The Ministry's guidelines include the following:

- Services provided must comply with the 1.5 metre social distancing rule.
- Workers in shelters must wear PPE if they are providing medical treatment within a distance of 1.5 metres.
- In addition to providing a safe place to sleep, municipalities must ensure that homeless people have somewhere to go during the day where they can have a meal and take care of their personal hygiene needs.

[5] Parliamentary Papers, House of Representatives 2019-2020, 2020D32689.
[6] https://www.rijksoverheid.nl/documenten/richtlijnen/2020/03/27/richtlijn-opvang-van-dak--en-thuisloze-mensen.

Central government has compensated municipalities for the cost of these measures. A further €200 million will be made available in 2020 and 2021 to reduce and prevent homelessness in the Netherlands. This central government funding will be divided among municipalities and used for: 1. prevention of homelessness; 2. new shelters; and 3. assisted housing. The aim is to house 10,000 people under this plan by the end of 2021.

c) *If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised*