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REVISED EUROPEAN SOCIAL CHARTER

2nd National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF THE NETHERLANDS

(Articles 3§1, 3§2, 3§3, 12 and 13
for the period 1 January 2005 - 31 December 2007
Articles 11 and 14
for the period 1 January 2003 - 31 December 2007
Articles 3§4, 23 and 30
for the period 1 July 2006 – 31 December 2007)

Report registered by the Secretariat on 10 April 2009

CYCLE 2009

THE EUROPEAN SOCIAL CHARTER

The Netherlands' Twenty-first Report

for the period 1 January 2005 - 31 December 2007

on Articles 3, 12 and 13

and for the period 1 January 2003 - 31 December 2007

on Articles 11 and 14

and a first report on Articles 23 and 30

Report

For the period 1 January 2005 to 31 December 2007 (Article 3, 12 and 13)
and for the period 1 January 2003 - 31 December 2007 (Articles 11 and 14)
and a first report on Articles 23 and 30,
made by the Government of the Netherlands in accordance with Article C of the Revised
European Social Charter, on the measures taken to give effect to the accepted provisions of
the European Social Charter.

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

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

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

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Article 3 – The right to safe and healthy working conditions

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

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

Article 3§1

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

As of 1 January 2007 the Working Conditions Act (Arbeidsomstandighedenwet) was amended with a view to achieving more effective health and safety policy that enjoys more support from companies, thus improving safety and health in the workplace. A good health and safety policy helps prevent work-related illness and accidents and raises productivity.

The review of the Working Conditions Act changed the way responsibilities are divided between the government, employers and employees. In the public sphere, the government provides a clear legal framework that goes beyond the EU-requirements, with a minimum administrative burden and no superfluous rules, and with good enforcement and public information. The legislation sets out clear and enforceable rules associated, where possible, with specific scientifically underpinned health and safety targets. These targets specify the level of protection that employers must provide for employees to enable them to work safely and healthily.

In the private sphere, the social partners agree on how the public targets are to be met in their sector. These agreements may be recorded in a 'health and safety catalogue'. The social partners are responsible for producing, designing and supplying the content and publicity for the catalogues.

The government, social partners and health and safety experts consult and collaborate in various settings. They include:

- the Health and Safety Committee of the tripartite (employers, employees and independent experts) Social and Economic Council of the Netherlands (SER);
- a subcommittee of the SER Health and Safety Committee which is recommending the government on the safety and health regarding the occupational exposure to dangerous substances;
- the Labour Foundation (a bipartite body for social partners), which advises the government on the health and safety issues associated with hazardous substances;

- limits for carcinogenic substances and the like are set in consultation with the Health Council. Such limits are discussed with the SER Health and Safety Committee;
 - The Health Council which advises in the framework of the development of scientifically underpinned targets
- 2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the national policy in consultation with employers' and workers' organisations.*

The government supports employers and employees, companies and sectors in the implementation of policy. A range of instruments has been developed, and information is gathered and disseminated for this purpose. Specific programmes have also been developed and implemented in collaboration with social partners/sectors. These include:

- an SME (Small and Medium Enterprises) health and safety activities programme targeted specifically at small companies;
 - instruments for risk identification and assessment, particularly for SMEs;
 - a programme to promote safety culture in companies;
 - a project on working with chemicals;
 - voluntary agreements on health and safety (in the period 1999-2007, in over 50 sectors).
- The results were used to produce the health and safety catalogues mentioned above.

It is the government's aim to achieve health and safety facilities and a health and safety culture that helps social partners fulfil their responsibility for health and safety in the workplace. A website, www.arboportaal.nl, is being set up to provide information on health and safety. The site will enable users to find information relevant to them from various search angles.

In collaboration with the Labour Foundation, a temporary grants scheme has been established to promote the production of health and safety catalogues (subsidiering Stimulerend Totstandkoming Arbocatalogi, STA), which will run from 2007 to 2009. Under the scheme, sector organisations can apply for funding to help cover the costs of producing a health and safety catalogue. The scheme is also funding a Labour Foundation project for the same purpose (Tijdelijke Ondersteuning van de Totstandkoming van Arbocatalogi), which will run over the same period. The committee set up to oversee the project supports and advises sector organisations drawing up health and safety catalogues.

The legislation stipulates that risks in the workplace must be identified and assessed. In collaboration with the social partners, the government has developed digital instruments for companies to use in risk identification and assessment (RI&A). The government is subsidising the social partners' efforts to publicise these instruments, encourage their use and promote the development of more instruments. For a list of the instruments, see www.rie.nl.

The government is currently working with the social partners to identify ways of encouraging RI&A compliance in small companies. One option would be to simplify the digital RI&A instruments, and the possibility of doing so under the current RI&A system is now being explored.

Employers are obliged to observe limits for the chemicals they use. Only certain substances that meet certain criteria are eligible for designated limits, in compliance with the European rules (REACH). The social partners have developed a website with the aim of obtaining and applying such limits and thus reducing health risks. This project has been funded by the

government. The site, which is the intellectual property of the social partners, will be online by the end of 2009.

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

The current state of workplace health and safety in the Netherlands is measured every year and reported in the Health and Safety Review (Arbobalans). The most recent edition of the Review is enclosed. It presents figures on accidents at work, among other things. Table 3.18 on page 71 sets out figures which show that the number of fatal accidents is falling. The Health and Safety Review also contains figures on various risks to health and safety in the workplace.

⇒ Annex 1: Arbobalans 2006

Employers are obliged to report serious accidents, especially those leading to hospitalisation, permanent damage to health or death. The most recent edition of the Monitor of Workplace Accidents in the Netherlands (Monitor Arbeidsongevallen in Nederland 2005) is also enclosed (the 2006 edition is not yet available). This publication contains a variety of information on workplace accidents in the Netherlands. It shows a downward trend in the number of fatal accidents (see pp. 29 and 30). Table 18 on page 31 shows the number of workplace accidents per 100,000 workers in the Netherlands and Europe.

⇒ Annex 2: Monitor Arbeidsongevallen in Nederland 2005

The Netherlands Centre for Occupational Diseases (NCvB) produces an Alert Report on Occupational Diseases every year with the aim of providing information useful for policymakers. The report presents figures on the incidence of occupational diseases and their distribution among sectors and professions. It also describes trends. According to the NCvB the report identifies points requiring preventive measures or further research for policymakers and professionals working in workplace health and safety. The most recent edition, which includes an English summary (Chapter 15, p. 119), is enclosed.

⇒ Annex 3: Signaleringsrapport Beroepsziekten '07

Article 3§2

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

As stated above under article 3 §1 question 1, the Working Conditions Act has been amended. We have also looked in detail at the reasons for and implications of the changes, as well as the legal framework and the involvement of the social partners. To summarise: the government provides a clear legal framework, and the social partners agree how the public targets are to be met. They may record what they have agreed in a health and safety catalogue.

The most important changes introduced in 2007 are listed below:

- The general obligation for employers to run an occupational health surgery has been abolished; instead, the risk identification and assessment must include employee access to a health and safety expert, who need not be a company doctor.
- In-house emergency response is to change in the sense that the size of the emergency response team and the way emergency response is organised will depend on the risk identification and assessment, and the employer may take on emergency response tasks himself, provided he has arranged cover.

- The reporting and recording of accidents has changed. Employers are now obliged to report any serious accidents involving their staff during work hours to the Labour Inspectorate. Workplace accidents must be reported if they are fatal or lead to hospitalisation or permanent injury. The distinction between physical and psychological injury has been abandoned. The Labour Inspectorate investigates all reports of accidents. Employers are obliged to submit a written report only if the Labour Inspectorate requests that they do so.
 - In organisations with up to 25 employees, the employer may act as prevention officer.
 - The concept of psychosocial burden now includes bullying and pressure of work, as well as sexual harassment, aggression and violence. Employers are obliged to pursue a policy designed to prevent psychosocial burden.
 - Employers are no longer obliged to produce an annual written report on the implementation of the action plan for tackling risks within their organisation.
 - The RI&A check for companies with up to 25 employees has changed. Provided the RI&A has been drafted using an instrument stipulated in the collective agreement for the sector agreed by the social partners and the parties to that agreement have had that instrument verified by at least one recognised health and safety expert, the organisation's RI&A does not need to be independently verified by a health and safety service.
- 2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework in consultation with employers' and workers' organisations.*

See answer under Article 3§1 question 2

Article 3§3

- 1) *Please describe the enforcement of safety and health regulations. Please specify the nature of, reasons for and extent of any reforms.*

Enforcement system

The purpose of the Labour Inspectorate is to identify and tackle violations of the legislation pertaining to health and safety in the workplace, working hours, the Foreign Nationals (Employment) Act (Wet arbeid vreemdelingen), the Minimum Wage and Minimum Holiday Allowance Act (Wet op het minimumloon) etc. The Labour Inspectorate also encourages the social partners to create conditions in their sector that enable companies to comply with their statutory obligations.

The Labour Inspectorate's remit covers the entire economy, including the public sector, which includes the army and police, education and health care, and home workers. It also covers self-employed people with no staff, but only to the extent that they are subject to health and safety legislation, i.e. in terms of serious risk. For a more detailed description of the enforcement system, see the 19th report and appendices.

Substance and nature of the reforms

At the core of the Ministry of Social Affairs and Employment's revised health and safety policy lies a greater role for the social partners. In particular, they now have more scope to decide how to comply with legal norms. Reducing the administrative burden is another key aim of government policy.

The Labour Inspectorate has attempted to achieve this by means of:

- a new sectoral approach, including health and safety brochures for individual sectors;
- the introduction of a ‘new inspection philosophy’, with more discretion for inspectors;
- sector-wide coordination of inspections and collaboration between inspection services.

The new Working Conditions Act of 1 January 2007 allows the social partners to draw up health and safety catalogues to meet the statutory targets for their sector. The Labour Inspectorate has produced sectoral health and safety brochures and developed a sector-specific approach to tie in with the actions of the social partners in the different sectors. The more actively these parties are engaged in promoting compliance with the legislation, the fewer inspections the Labour Inspectorate will conduct. The sectoral brochures it has produced are designed to help with compliance, setting out the key risks and statutory targets for the sector. The brochures are widely distributed in a sector prior to any inspection project. One side-effect has been that the perceived likelihood of inspection now exceeds what is actually feasible.

The new inspection philosophy has given inspectors more discretion in their enforcement work. They can opt not to use official enforcement instruments in the case of minor infringements if they believe that the employer generally has a positive attitude and has health and safety more or less in order. Inspectors are also free to decide whether a repeat inspection is needed. Previously, every warning, demand or fine was followed up by a repeat inspection. Inspectors are now free not to repeat the inspection if they have confidence in the organisation.

Dutch government policy on supervision has been set out in a policy document defining a framework for supervision (Nota kaderstellende visie op toezicht). Key elements include reducing the administrative burden of inspections and the pressure of inspections through better coordination between supervisory bodies. For this purpose, eleven domain/sector inspection desks have been established, each of which is managed by one of the supervisory bodies responsible for inspection in the sector. A large number of collaborative projects have also been launched, some of which involve a different division of tasks, or supervisory bodies standing in for or alerting each other.

- 2) *Please provide pertinent figures, statistics (for example Eurostat data) or any other relevant information on the number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardised accident rates per 100,000 workers; on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections; and on the number of breaches to health and safety regulations and the nature and type of sanctions imposed.*

Accident statistics, including fatal accidents:

In the Netherlands, in 2006, there were:
about 225,000 accidents, 80 of which were fatal

Figures per 100,000 workers:

3,100 workplace accidents leading to injury and absence

2,400 workplace accidents leading to an absence of more than three days

one fatal accident¹

¹ NEA 2006

In 2006, under a new statutory obligation applying to health and safety services, 5,480 cases of occupational disease were reported to the Netherlands Centre for Occupational Diseases. In 41% of cases, these were diseases of the skeletomuscular and nervous system, 22% were psychological disorders and 28% involved deafness.²

Number of inspection visits in 2007

In 2007 the Labour Inspectorate paid almost 20,000 inspection visits to companies. In that year, there were 580,000 company establishments in the Netherlands. (Those 580,000 establishments include enterprises of independent entrepreneurs without workers.)

The Labour Inspectorate has a total workforce of 882 FTEs, 455 FTEs of which are accounted for by inspectors, while 291 FTEs are devoted to the supervision of health and safety in the workplace. Some 50% of the available capacity of health and safety inspectors is devoted to proactive inspections, the rest to investigations in response to complaints and accidents. Proactive health and safety inspection projects are implemented on a sectoral and on a nationwide basis.

In 2007 a total of 3,543 accidents were reported to the Labour Inspectorate and 2,300 were investigated.

55% of health and safety inspections led to interventions, ranging from measures to encourage compliance to cessation of activity.

Under the Working Conditions Act, interventions were carried out in the following areas (listed in order of frequency):

1. equipment
2. layout of workstations
3. hazardous substances
4. physical burden
5. risk identification and assessment and/or action plan.

In 2007 2,089 fines totalling €7 million were imposed under administrative law for non-compliance with the Working Conditions Act and the Working Hours Act (Arbeidstijdenwet). Several official reports were also filed with the Public Prosecution Service.

Article 3§4

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

Every company must conduct a risk identification and assessment (RI&A). This requires expertise, which should preferably be present within the company itself. If this is not possible, or cannot be achieved to an adequate standard, an internal or external health and safety service and/or an external health and safety expert can be brought in.

Employers must seek support in performing the following tasks:

- verifying the RI&A
- sickness counselling

² Netherlands Centre for Occupational Diseases: Alert Report on Occupational Diseases 2006.

- regular work-related medical examinations
- any medical examinations performed when staff join the organisation.

Since 2005, companies have been obliged to appoint a prevention officer – a member of staff who is concerned with health and safety in the workplace. In companies with no more than 25 staff, the employer may take on this role himself.

Furthermore, since 2005 companies have been given the freedom to decide for themselves how to arrange prevention activities and sickness counselling, and what expertise to bring in for the purpose. Prior to that, companies had to have a contract with a health and safety service. As part of the deregulation of health and safety services, it was decided that employers should be given the opportunity to arrange the expert support needed for prevention and counselling as they see fit, provided the employee participation body agrees with the employer on the arrangements. Two further conditions must be met: a company doctor must be involved in sickness counselling, health and safety investigations and initial medical examinations, and a certified health and safety expert must verify the RI&A.

Finally, companies no longer need to run an occupational health surgery as of 2007.

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

As part of the deregulation of health and safety services – giving employers more choice in how they organise things – an RI&A compiled using an instrument agreed by the social partners in or under a collective agreement need not be verified by a health and safety service if the company has no more than 25 staff.

The small and medium-sized employers' organisation MKB Nederland has also received funding for a project to improve health and safety services for SMEs and the sectors in which they are active. It is also exploring, in consultation with the social partners, the extent to which the RI&A system can be simplified. This is partly to assess whether the system is consistent with the 'new' roles and responsibilities set out in the revised Working Conditions Act, which entered into force in 2007. The role of health and safety services and experts is also being reconsidered.

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

The Netherlands has a nationwide system of health and safety services. A list of certified services and a list of in-house health and safety services are enclosed.

Questions from the European Committee of Social Rights in response to the previous (19th) Dutch report

Paragraph 1

- a. – *Protection of workers against asbestos.*
The Committee asks again whether measures are being taken to compile a list of buildings containing asbestos.

In the Netherlands, any owner who wishes to partially or completely demolish or alter his building has a statutory obligation to commission an asbestos identification report from a company certified for the purpose by an institution designated by the Minister of Social Affairs and Employment. Such a report must be produced before demolition or building work can commence.

b. – *Protection of temporary workers*

The Committee nevertheless asks the next report to provide concrete examples of how health and safety regulations apply on an equal basis to all employees irrespective of their work relationship, and in particular, to clarify whether temporary workers are informed/trained upon recruitment, in the event of a change of job or in the event of the introduction of new equipment or technology on the same standing as permanent employees.

In reply to the Committee's question of how regulations in the Netherlands apply the Charter case law in this field – i.e. the requirement to provide temporary workers with information, training and medical surveillance adapted to their employment status to avoid any discrimination in respect of health and safety in the workplace – the report reiterates that the Working Conditions Act makes no distinction in terms of statutory protective measures between temporary and full-time or part-time workers. The Committee nevertheless asks for the next report to provide concrete examples of how health and safety regulations apply on an equal basis to all employees irrespective of their work relationship, and in particular, to clarify whether temporary workers are informed/trained on the same footing as permanent employees upon recruitment, in the event of a change of job or in the event of the introduction of new equipment or technology.

Equal treatment of temporary workers is guaranteed under the Working Conditions Act and the Placement of Personnel by Intermediaries Act (Wet Allocatie Arbeidskrachten door Intermediairs). The employer responsible for health and safety policy according to Dutch law is the employer exercising authority over the actual performance of the work. Normally it is the hiring company that gives the orders. The hiring company is responsible for providing information and training, supplying the necessary personal protective equipment, organising sickness counselling etc., except when a company is contracted to provide certain services or perform certain tasks with its own supervisors.

Employment agencies also have obligations, however. These include equal pay, under the Placement of Personnel by Intermediaries Act. They also have an obligation to inform potential workers correctly about the type of work they will be required to perform and the hazards identified in the risk analysis. They must recruit on the basis of competences, and of health and safety knowledge and standards, if these are specific to the work in question. The Ministry of Social Affairs and Employment, employment agencies and social partners have signed a voluntary agreement on health and safety designed to reduce sickness absence through concerted action.

Special projects have been conducted by the social partners with government support to develop good health and safety information, raise health and safety awareness among employment agency staff etc. This process continues as part of the Labour Inspectorate's sectoral approach for this sector.

In 2002 and 2006 the Dutch labour inspectorate ran specific inspection projects to ascertain whether the companies hiring temporary staff inform, train, recruit and equip them as well as permanent staff. The 2006 project focused specifically on the treatment and recruitment of

foreign temporary workers. Other temporary workers and their training are a specific focus of sectoral projects in sectors with many temporary workers, and of accident investigations involving temporary workers. A specific programme was launched in 2007 to visit all fruit farmers with low-oxygen refrigeration cells to inspect the quality of the health and safety information about the risks associated with these cells supplied to the many temporary workers in this sector who often do not speak Dutch.

The overall results of these projects show no structural or intentional discrimination against temporary workers.

We did not find significant more dangerous work being attributed to temporary workers than to the workers on a permanent labour contract, nor less or lesser quality of personal protection equipment or lower quality of working equipment. Nor did we find significant more excessive working hours or forms of intimidation of temporary workers. However information provision and training of temporary workers regarding health and safety aspects were insufficient in one out of five inspected work situations, and therefore remain issues that require the permanent attention of the Inspectorate. This applies to all economic sectors with a large proportion of temporary workers, but specifically to those with many non-Dutch-speaking temporary workers.

c. Personal scope of the regulations

The Committee asks to be kept informed on the adoption of any new regulations or measures aimed at improving the protection of the health and safety at work of self-employed workers, including on the question of the definition of a 'self-employed person without staff', which has in the past been considered a problematic one in the Netherlands.

Partly in response to the 2004 report by the Social and Economic Council referred to in the question, self-employed persons are now covered by the legislation. This is reflected, inter alia, in section 16, subsection 7 of the Working Conditions Act, which stipulates that an order in council may be issued to the effect that the obligation to comply with the Working Conditions Act and any provisions based on it also applies to self-employed persons, in so far as they refer to work involving particular risks to health or safety. Chapter 9, part 1, article 9.5 of the Working Conditions Decree (Arbobesluit) sets out these provisions. Serious risks are defined (and include exposure to hazardous substances and falling from a height). The decree also stipulates that self-employed persons are obliged, in situations in the construction sector where several employers commission work, to cooperate with them in an effective manner. The Working Conditions Act also stipulates that self-employed persons must ensure that any threat to third parties is prevented. We are of course willing to inform the Committee of any new legislation and/or policy in this area.

Paragraph 2

d. The Committee notes that the frequency of visits and the proportion of employees covered by them have decreased, although very slightly, in comparison to the last reference period and asks for an explanation of this.

The major reorganisation that took place in 2004 may have caused some loss of productivity in certain fields.

e. The Committee also wishes to receive an explanation for the divergence in the number of inspection visits for 2004 quoted in the report and those which appear in the data

submitted by the Netherlands to the European Commission for the drawing up of 'Annual Reports of the Labour Inspectorate'.

In 2004 the Labour Inspectorate completed a total of 36,383 **inspection procedures**

General health and safety	20,258 procedures complete
Working hours	430 procedures complete
Illegal employment	5,950 procedures complete
Health and safety complaints	2,440 procedures complete
Major hazard control	281 procedures complete
Other reactive work	885 procedures complete
Desk studies	2 procedures complete
Permits etc.	3,502 procedures complete

See annual report, page 44

The report of the Senior Labour Inspection Committee (SLIC) refers to 53,259 **visits** (page 4, table 1.2):

1. SLIC focuses on health and safety in a broad sense, but not illegal employment or monitoring wages. The figure refers only to visits for general health and safety inspections, working hours inspections, major hazard control inspections, accident inspections, complaints and other reactive health and safety inspection activities.
2. A 'trajectory' (or inspection procedure) is not the same as a 'visit'. One inspection procedure often requires several inspection visits.

Article 11 – The right to protection of health

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

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

Article 11§1

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

Public Health Act (WPG)

The Public Health (Preventive Measures) Act has recently been replaced by the Public Health Act. The Public Health Act replaces three pieces of legislation relating to public health: the Infectious Diseases Act, the Quarantine Act and the Public Health (Preventive Measures) Act. Most amendments concern infectious disease control.

Background

This new legislation was prompted by new international obligations in the field of infectious disease control, as set down in the International Health Regulations (2005) (IHR; Dutch Treaty Series, 2007, 34). They replace the old International Health Regulations of 1969, which had been set out in the Dutch Quarantine Act. The objective remains unchanged: to limit the risk of the international spread of infectious diseases (influenza pandemic, SARS). Member states' obligations have been extended, however. For example, more diseases must be reported to WHO and the infectious disease control system has to meet specific requirements. Member states are also obliged to identify places where there is an increased risk of introducing or spreading infectious diseases and to report these to WHO. Additional precautions must be taken in these places to prevent and/or control infectious diseases. With the introduction of the Public Health Act, the Netherlands is fulfilling its obligations in this respect.

Powers of the Minister of Health, Welfare and Sport

The basic structure of the infectious disease control system in the Netherlands remains unchanged. The municipal executive is responsible for preventing outbreaks of infectious diseases and for taking preparatory measures. The mayor is still responsible for taking action in the event of an outbreak. One new element is that, in precisely defined situations, the Minister of Health, Welfare and Sport can guide the mayor in the performance of his tasks and can instruct the municipal executive to make preparations. This occurs in serious situations that extend beyond municipal boundaries and where it is important to pursue a uniform policy nationwide.

Powers of the mayor

The powers of the mayor to place infected individuals in isolation, have them examined by a doctor and/or prohibit them from exercising their professional activity are fully maintained. The mayor also retains the power to order quarantine measures. With regard to the infection of buildings, goods and conveyances, the current powers are insufficient to comply with the IHR. This applies throughout the Netherlands. Mayors are therefore to be given additional

powers to act. For instance, every mayor in the Netherlands will have more scope to disinfect buildings, goods and transport vehicles. At the moment the ability to take such measures is limited to situations where there is *grave danger* of a *notifiable* infectious disease spreading. In future it will be possible to take such measures in the event of *infection* by *any* infectious or toxic agent or substance and *any* vector (an insect, for example) that may constitute a public health risk.

Changes concerning duty to report infectious diseases

The new legislation introduces a number of changes concerning the duty to report infectious diseases. Some diseases have been added, for example because they are new or because there are now effective methods of control. A few diseases are no longer notifiable, for example because they no longer occur or because no control measures can be taken. A general duty to report diseases of unknown cause is also to be introduced if these might pose a serious threat to public health.

Entry points

In addition to the above, the new Act has a separate section on entry points, i.e. ports and airports where there is an increased risk of introducing infectious diseases. The Minister of Health, Welfare and Sport will designate these ports and airports, which will be required to introduce supplementary measures. The mayors responsible for these entry points are to be given additional powers. Specifically, this refers to the power to grant or refuse ships or aircraft *free pratique*, the power to demand information about the state of health of passengers or crew on board a ship or aircraft and the power to require cooperation from port and airport operators and transport companies.

In relation to entry points, besides the usual obligation of doctors to report cases to the Municipal Health Services, the captain of a ship or aircraft also has a duty to report any confirmed or suspected cases of serious infectious disease on board.

Finally, under the new IHR, sanitation certificates must be issued in designated ports. These replace the old deratting certificates and serve as proof that a ship is free from infection. Mayors with a designated port within their jurisdiction are authorised to issue these certificates, at the request and expense of the ship's captain.

National prevention policy

In 2006 the government published a policy document entitled '*Kiezen voor een gezond leven*', promoting healthy lifestyle choices. This document identifies a number of priorities to be addressed in national prevention policy: smoking, alcohol abuse, obesity, diabetes and depression. The government's prevention strategy was presented in 2007 and describes health policy centred on four main themes:

1. nurture and innovate

In other words, continue with existing policy on health protection and sickness prevention, p.e. the population screening programmes for breast cancer and cervical cancer.

2. cohesive, integrated health policy

Identifying and defining mutual interests between numerous civil society organisations and the business community.

3. prevention in health care

Linking primary, secondary and tertiary preventive and curative health care.

4. in the administrative environment: link up, collaborate and modernise

Improving public health care. In the Netherlands this primarily means strengthening local authorities' working relationship with the Municipal Health Services, who are their main partners in implementing public health policy.

In developing the above themes, the focus is on the following principles: there is parallelism of interests, effectiveness is treated as the norm and the healthy option is paramount, bearing in mind the easy or only option. Attention is devoted to innovative communication and learning from other countries and other sectors, with the emphasis firmly on young people when developing prevention policy.

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

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

1. nurture and innovate

- The Public Health Act is currently making its way through Parliament and describes in greater detail how the public health system works.
- A framework paper on screening has been issued, stating the government's view that products used to test health should meet minimum quality requirements. There should also be reliable information available on medical screening.
- Research commissioned by the ministry is examining the cost-effectiveness of health promotion initiatives.
- Local policy handbooks have been developed based on the five key priorities of the Ministry of Health, Welfare and Sport (smoking, alcohol, obesity, diabetes and depression).
- The population screening programmes (p.e. breast cancer, cervical cancer, neonatal screening) are very successful and can still be improved thanks to new technologies.

2. cohesive, integrated health policy

- Smoking has been banned in restaurants, cafés, bars, clubs and other catering establishments since 1 July 2008.
- Policies are being formulated on obesity and on reducing or eliminating socioeconomic health disadvantages.

3. prevention in health care

- A pilot project is under way promoting 'exercise on prescription', where GPs can prescribe a programme of exercise for people who are overweight, diabetic or at risk of developing diabetes. The general objective is to explore the possibility of including more preventive measures in the standard package of healthcare services.
- Policy initiatives are being carried out to link prevention and cure more effectively.

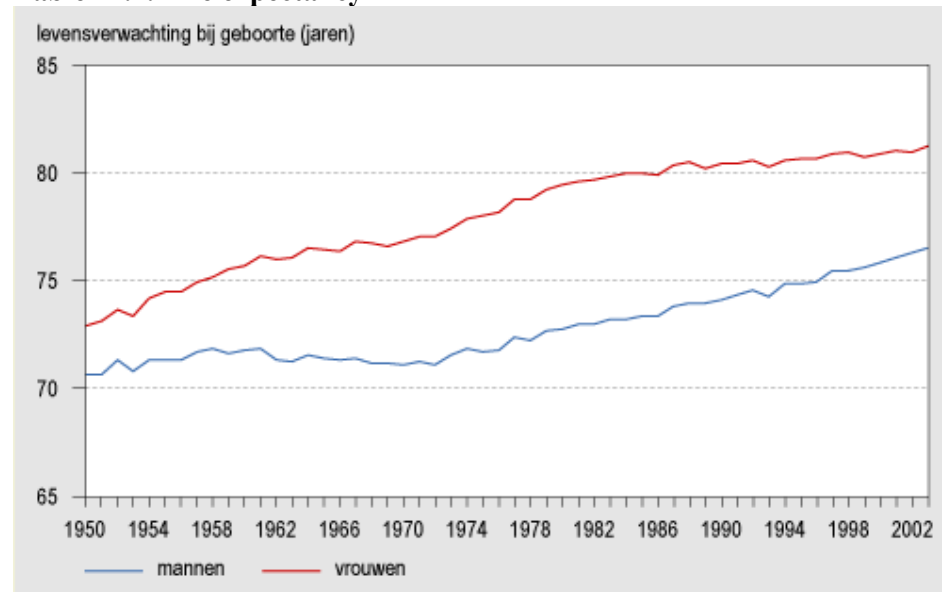
4. in the administrative environment: link up, collaborate and modernise

- Several projects are under way aimed at improving public health care.

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

Data from the National Institute for Public Health and the Environment (RIVM) indicates that life expectancy is increasing, for both men and women (see Table 1).

Table 11.1. Life expectancy



Life expectancy at birth (in years)
Men - Women

Health services and professions

According to RIVM data, most health services are provided by hospitals and facilities for the elderly. In 2003 hospitals accounted for the largest proportion of healthcare costs (26.9%), followed by the nursing, residential and home-care sector (21.3%). Medicines and medical aids are in third place with 13%. GP care (3.7%) represents a small proportion, but this says little about the importance and the work of this professional group. The proportion of preventive health care is low (1.3%), but by no means all preventive measures have been included.

Article 11§2

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

Not applicable.

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

Not applicable.

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

For the population as a whole, expenditure on preventive measures against infectious diseases, as well as measures to promote and protect health, is shown in the table below.

Table 11.2. Expenditure on preventive measures against infectious diseases, broken down by prevention method

Measure	Expenditure in € million (2003)
<i>Health protection</i>	
Food safety activities (VWA/KvW/RVV ¹)	155.9
Drinking water quality (drinking water supply, inspection)	1,466.0
Swimming water quality	17.7
Sewer system (cost of collecting waste water)	797.1
Waste: household waste management, Environment Inspectorate, police checks on waste	1,604.0
Hygiene checks: inspections of childcare facilities, sex encounter establishments and saunas	6.5
<i>Health promotion</i>	
Campaigns / information: AIDS Fund Foundation /AIDS Support Foundation	6.0
Information and prevention projects: Rutgers Nisso Group	13.2
Condom use	
<i>Sickness prevention</i>	
National immunisation programme (vaccination against mumps, measles, diphtheria, pertussis (whooping cough), poliomyelitis, tetanus, German measles, Hib)	53.1
Hepatitis B vaccination	3.6
Influenza vaccination	33.4
Travel vaccination	14.6
STD screening	14.6
Tuberculosis screening (including TBC screening by KNVC Tuberculosis Foundation and TBC screening of asylum seekers) and population screening	23.3
Blood screening for hepatitis B	2.5
Total	4,211.5

1 VWA: Food and Consumer Product Safety Authority;
KvW: Inspectorate for Health Protection and Veterinary Public Health;
RVV: National Inspection Service for Livestock and Meat.

Working specifically with children and adolescents, organisations implementing youth healthcare policy, home-care organisations and Municipal Health Services have operated in line with a basic set of statutory tasks relating to youth health care since 1 January 2003. These stipulate the public healthcare services available for young people up to the age of 19.

The basic set of statutory tasks relating to youth health care comprises six closely related elements:

Monitoring and reporting.

1. Assessment of healthcare needs.
2. Screening and vaccinations, which are available to every child at health clinics under the national immunisation programme. Hearing and eyesight are also tested.
3. Information, advice, training and counselling.
4. Countering of health threats.
5. Healthcare system, networks, consultation and collaboration.

Article 11§3

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

Not applicable.

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

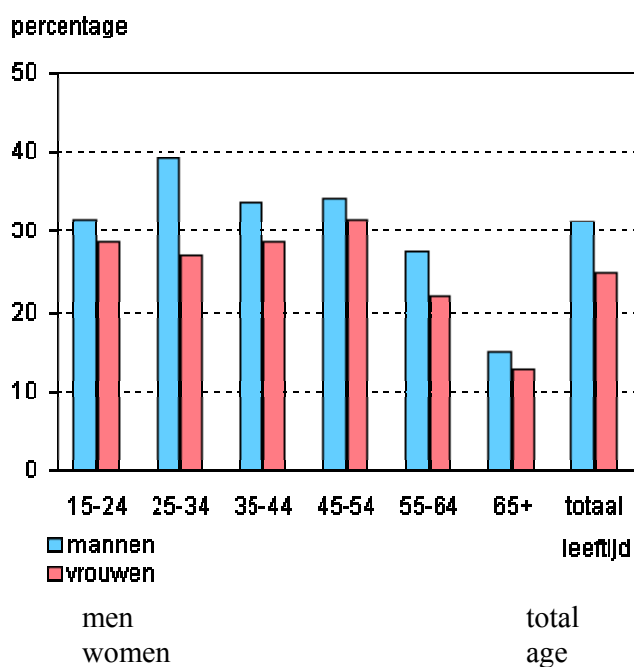
Not applicable.

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

Percentage smokers in the general population

According to RIVM statistics, just over a quarter of Dutch people smoke. In 2006, 28% of all Dutch people aged 18 and over were smokers: more men smoke than women in all age groups (31% versus 25%) (source: the Public Health and Smoking Organisation (STIVORO), adults). The percentage of smokers is particularly high among men aged between 25 and 35, and lowest among people over the age of 65 (see Table 3).

Table 11.3. Percentage of smokers in 2006, broken down by age and sex (source: STIVORO, adults)

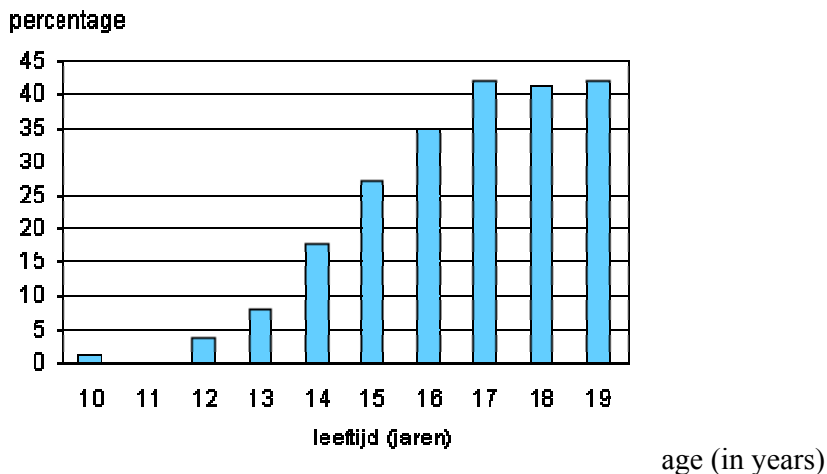


In 2006 male smokers smoked an average of fifteen cigarettes a day, compared with fourteen for women (STIVORO, adults). In the same year, statistics for young smokers between the ages of 10 and 20 were as follows: the youngest smokers (10 to 13-year-olds) smoked an

average of two cigarettes a day, 13 and 14-year-olds five, and 15 to 20-year-olds seven (source: STIVORO, young people).

It can be inferred from the graph below that an average of 22% of young people (10 to 20-year-olds) report having smoked in the past four weeks, 1% of the youngest group and 40% of the oldest (17 and over). Nearly half (44%) of young people have smoked on at least one occasion (source: STIVORO, young people).

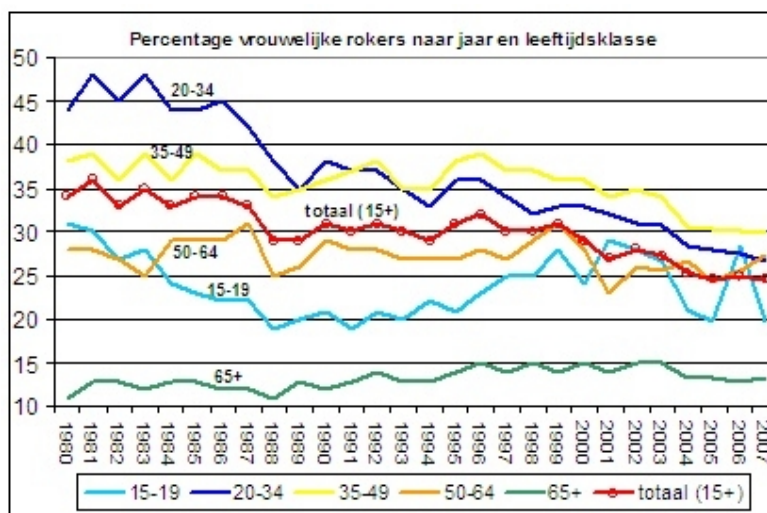
Table 11.4. Percentage of young people (10-20 age group) who reported having smoked in the past four weeks (2006), broken down by age (STIVORO, young people).



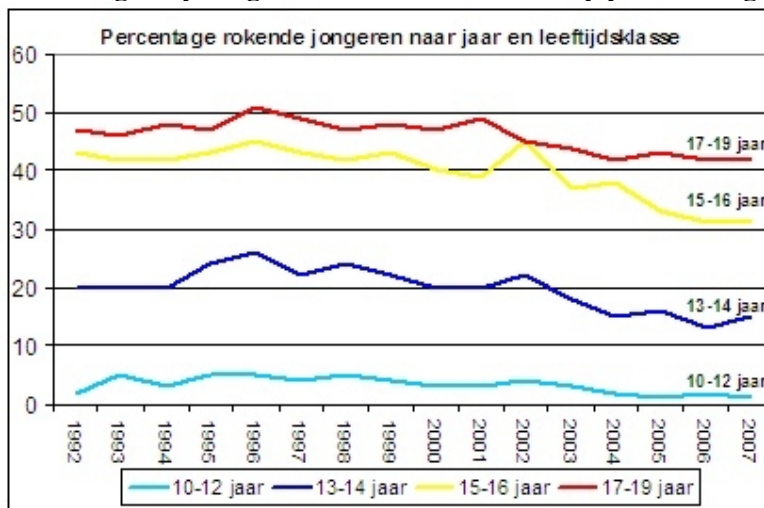
Number of smokers down slightly

Among people aged 15 and over there has been a slight drop in the percentage of smokers from 28.2% in 2006 to 27.5% in 2007. The percentage of heavy smokers in the 12+ age group also fell from 7.2% to 6.7%. People requiring help for a tobacco addiction are mainly seeking a self-help option or advice from their family doctor. In 2006 an estimated 42,800 men and 42,100 women consulted their GP about giving up smoking, a total of 24% fewer than in 2005. The market for nicotine-replacement products (patches, chewing gum, tablets) grew between 2006 and 2007. Various campaigns are designed to encourage smokers to give up.

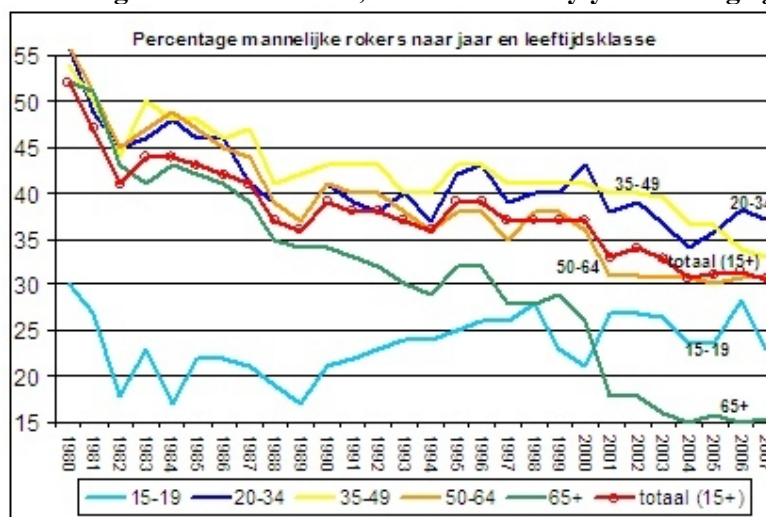
Tabel 11.5 Percentage of female smokers, broken down by year and age group



Tabel 11.6 Percentage of young smokers, broken down by year and age group



Tabel 11.7 Percentage of male smokers, broken down by year and age group



Trends in alcohol consumption

According to the RIVM, most Dutch people – both men and women – drink alcohol: 81% of the population (aged 12 and over, in 2006). There are more female non-drinkers: 24% of women report they never drink, versus 14% of men. About half of all young people between the ages of 12 and 16 regularly drink alcohol (consumption in the past month: 48% in 2005). There is a point at which a crucial change occurs within this age group, however. At the age of 12 or 13 non-drinkers are in the majority, but from the age of 14 they are in the minority (Van Dorsseleer et al., 2007).

Young Dutch people start drinking alcohol at a young age. Sixty per cent of 12-year-old school-goers have drunk alcohol on at least one occasion, rising to 86% of 16-year-olds. More than 1 in 5 12-year-olds (22%) and 71% of 16-year-olds consume alcohol regularly (consumption in the past month). There is no difference in the percentages of boys and girls who drink, though boys do have a more harmful drinking pattern than girls (Van Dorsseleer et al., 2007).

Slight increase in the number of alcohol-related hospital admissions

The numbers of recent and current consumers of alcohol in the population aged 15-64 remained stable between 2001 and 2005 (in 2005: recent 85%, current 78%). The percentage of people who consumed six or more glasses of alcohol in one day on at least one occasion during the past six months dropped during this period from 40% to 35%. There are considerable differences between age groups, particularly as regards heavier alcohol consumption. Men aged between 18 and 24 score highest for heavy and problem drinking. In 2007, for instance, 38% of men and 14% of women in this age group were heavy drinkers (i.e. they had drunk at least six glasses of alcohol on one or more days per week). This is less than in 2002 (42% of men and 18% of women aged 18-24), but slightly more than in 2006 (36% of men and 10% of women aged 18-24). Alcohol consumption among juveniles has also attracted a lot of attention in recent years. The proportion of school-goers that drink alcohol at a young age increased between 1999 and 2003. They often start drinking between the ages of 11 and 14. However, among 12-year-olds there was a slight drop in the percentage of current drinkers between 2003 and 2005. Alcohol appears to be inextricably linked with night life. Among younger underage drinkers, there has been a marked increase in 'pre-drinking' at home before going out to socialise (to save money). Binge drinking among young people now appears to be the norm. Despite a statutory ban on selling alcohol to juveniles under the age of 16, they have no problem obtaining alcoholic beverages. In 2006, one-fifth of 12 to 16-year-olds reported having purchased alcohol. Of the approximately 1.2 million problem drinkers in the Netherlands, only a small number seek addiction treatment. Following an increase between 2001 and 2005 (39%), the number of clients treated for a primary alcohol problem fell by three percentage points in 2006 (30,000 clients). The number of hospital admissions for a primary diagnosis of alcohol abuse and dependence rose from 3,900 in 2001 to 4,500 in 2004. Between 2004 and 2005 the number of admissions remained fairly stable (4,553), but increased again by 7% between 2005 and 2006 (4,855). The number of people aged 16 and under admitted to hospital with an alcohol-related problem rose by more than 80% between 2001 and 2006.

Vaccination coverage against infectious diseases

The rate of vaccination coverage in the Netherlands is over 95%. As a result, the national immunisation programme is highly effective. Participation in this programme is voluntary (RIVM).

Questions from the European Committee of Social Rights arising from the Netherlands' previous report (17th).

Paragraph 1

a. Access to health care

The Committee refers to its last conclusion for a general description of the health care system (Conclusions XV-2, pp. 353-355). It asks for information in the next report on any changes to the legal situation.

Developments in the Dutch healthcare system

The Dutch government is committed to maintaining a healthcare system that provides people with access to essential medical care of good quality. For many years the Netherlands had a fragmented system of health insurance for standard medical care. This was due to historical factors. Until 1 January 2006, a system of compulsory health insurance covered a large section (about 60%) of the Dutch population. The remainder had to take out private health insurance. Some risk groups were able to obtain a policy covering a legally defined, standard

package of services. Certain groups of civil servants were covered by special compulsory private health insurance.

This fragmentation ended on 1 January 2006 with the introduction of a single statutory insurance regime that covers all residents of the Netherlands: the Healthcare Insurance Act (*Zorgverzekeringswet*). The new regime was designed to contribute to the fullest extent possible to the provision of effective, high-quality health care. The new system retains and, where possible, strengthens some established rights, such as the scope for private initiative, a relatively strong private-law basis with accompanying financial responsibilities for medical insurers and good accessibility. The former Health Insurance Act, the Medical Insurance (Access) Act 1998 and the Act governing the Joint Funding of Elderly Health Insurance Fund Patients were revoked on 1 January 2006. Insurance through health insurance funds and insurance under the Medical Insurance (Access) Act no longer exist.

The new Dutch health insurance system consists of three elements. The first is statutory insurance, covering the entire population, against the costs of long-term nursing and care. This entitlement is governed by the Exceptional Medical Expenses Act. The second element is insurance against the cost of care with a view to cure. Everyone resident in the Netherlands has a legal obligation to take out insurance of this kind. This requirement is laid down in the Healthcare Insurance Act. Together, the entitlements existing under the Exceptional Medical Expenses Act and the Healthcare Insurance Act offer all members of the public adequate cover against medical expenses. Everyone has the option of taking out supplementary insurance for types of care not covered by the Exceptional Medical Expenses Act or the Healthcare Insurance Act.

Healthcare Insurance Act (Zorgverzekeringswet)

The Healthcare Insurance Act makes it mandatory for everyone who resides or pays salaries tax in the Netherlands to take out health insurance. Every health insurance company in the Netherlands that has stated that it will provide services under the Act has a legal obligation to accept anyone who applies for insurance.

The Healthcare Insurance Act defines insurance cover with reference to different types of care. The care insurer may decide which qualified person or institution will provide the insured care. Similarly, the insurer may decide whether to provide the insured care to insured persons in kind or through reimbursement of costs they pay to the care provider they chose. In the latter case, the insurer has an obligation to help insured persons find available care if they request such assistance. It is also possible for the insurer to offer some types of care in kind and others through reimbursement.

An insurer must always offer insured persons an insurance option without a personal excess. As from 1 January 2008, the government introduced a statutory personal excess of €150 for each insured person aged 18 and over, in exchange for which the nominal premium (see below) was lowered. Chronically ill and handicapped persons receive compensation of €47. The insurer may offer a number of legally defined tranches of voluntary personal excess, also in exchange for a lower nominal premium.

People may choose any variant of insurance offered by the insurer. They may switch variant and insurer from year to year.

An insured person pays a nominal premium directly to the insurer and also an income-related contribution. The insurer decides the size of the nominal premium. Insured persons up to the age of 18 do not pay a nominal premium. The Tax and Customs Administration levy income-

related contributions. Employers are required to reimburse their employees in full for these contributions. With a few exceptions, people drawing social security benefits are also entitled to reimbursement of these contributions from the authorities that administer their benefits. It is up to pension administrators to decide whether to reimburse retired persons for all or part of the income-related contribution. The income-related contributions are deposited in the Health Insurance Fund along with a government contribution equal to the nominal premiums for insured persons younger than 18. One of the purposes of this fund is to pay insurers amounts related to the degree of risk of the people they insure.

Healthcare Benefit Act (Wet op de Zorgtoeslag)

The Healthcare Benefit Act took effect at the same time as the Healthcare Insurance Act. Under this Act, people receive a benefit if the nominal premium is excessive in relation to their income. The tax authorities pay out these benefits. The income of a person's partner is taken into consideration when determining whether somebody qualifies for a benefit.

Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten)

This Act provides for statutory insurance covering the entire population against the cost of long-term nursing and care. It has remained unchanged, except in one area. The government has introduced the Social Support Act (*Wet Maatschappelijke Ondersteuning*), which will gradually transfer responsibility to local authorities for elements of care currently covered by entitlements under the Exceptional Medical Expenses Act. The first step was the transfer of home care (without a nursing element) from the Exceptional Medical Expenses Act to the Social Support Act. Home care is now provided under the responsibility of the local authorities, which conclude contracts with home-care organisations.

For further information, the Committee is referred to the brochure: Health Insurance in the Netherlands, The new health insurance system from 2006.

⇒ Annex 4: Health Insurance in the Netherlands, The new health insurance system from 2006

b. *It also wishes to be informed of the content and implementation of the youth health care policy, which became a local authority responsibility in January 2003.*

The Netherlands has an extensive network of healthcare facilities. All young people up to the age of 19 have access to preventive youth health care. The aim is to identify risks at an early stage that might affect their physical, psychological, cognitive or social development. Youth healthcare services are provided as part of a programme, whereby all children undergo examination at least fifteen times (most often during early childhood) by the Municipal Health Services and health clinics. The overwhelming majority of children make use of these preventive services: more than 95% during early childhood, subsequently dropping to around 80%.

Central and local government each have their allotted tasks in the area of youth health care. Central government establishes the programme for all children and adolescents and promotes quality in implementation. The local authority is responsible for implementation and supplementing the national programme with activities that reflect local needs, ensuring that these tie in with local youth policy.

The national prevention framework contains a number of specific objectives for young people, such as reducing their burden of disease (especially asthma and diabetes) and improving their lifestyle to prevent disease later in life. The main focus is on tackling

smoking, obesity, drug use, sexually transmitted diseases and teenage pregnancy and abortion.

- c. *The Committee asks for precise information in the next report on measures to prevent health care costs from becoming an excessive burden on people with low incomes.*

As mentioned under the answer to question a, the government has introduced the Healthcare Benefit Act, under which people receive a benefit if the nominal premium is excessive in relation to their income. Anyone insured under the Healthcare Insurance Act qualifies for a healthcare benefit if the normative costs determined for his/her health insurance policy (called the 'normative premium' in the Healthcare Benefit Act) are less than the estimated average premium costs (called the 'standard premium' in the Healthcare Benefit Act). The healthcare benefit is equal to the difference between the two types of costs. The Benefits Unit of the Tax and Customs Administration checks whether anyone who applies for a benefit has actually taken out health insurance.

The normative costs of health insurance for an insured person with a partner have been set at 5% of the threshold income defined in the Healthcare Benefit Act, plus 5% of the means-tested income in excess of the threshold income. The normative costs of health insurance for an insured person without a partner have been set at 3.5% of the threshold income, plus 5% of the means-tested income in excess of the threshold income. These percentages may be adjusted by order in council. The Minister of Finance and the Minister of Social Affairs and Employment jointly determine these percentages. A person with personal assets does not lose entitlement to the benefit.

- d. *It also asks for detailed information on the reimbursement of medicines.*

Pharmaceutical care under the Healthcare Insurance Act consists of medicines and foods provided for medical purposes. In principle, the medicines covered by the insurance are divided into groups of medicines that are therapeutically interchangeable. The maximum reimbursement for such a group is set on the basis of the average price of the medicines in the group. An insured person who chooses a medicine that is more expensive must pay the difference. There is no reimbursement limit for a medicine that is covered and cannot be substituted by other medicines. This system is called the 'medicine reimbursement system'. With a view to the orchestration role that care insurers play, they are allowed to limit the reimbursable medicines to those they designate in each group. The definition of the care explicitly states that care insurers will designate medicines (subject to conditions). This was done to give extra emphasis to the role of healthcare insurers.

- e. *The Committee notes the government decision taken in 2002 to reduce the health disadvantage suffered by people on low incomes. It asks for detailed information in the next report on the measures taken – to be finalised in 2003 and 2004 – to disseminate models of good practice among local authorities.*

Socioeconomic health disadvantages are an important topic in health policy. One of the aims of the present Dutch government is to reduce differences in life expectancy based on socioeconomic background. One possible instrument is an effective prevention policy. Framework paper 2007-2011 stating the government's views on health and prevention (House of Representatives 22894, no. 134) outlines such a policy.

People whose health is more at risk because of their socioeconomic background are most likely to suffer an avoidable deterioration in their health. The Dutch government would like to help reduce these risks and improve socioeconomic health patterns. This will promote health in the Netherlands, stimulate social and economic participation and lead to increased prosperity and well-being. The positive effect of preventing a chronic burden of disease is that fewer people have recourse to the health system. Social justice is another reason for addressing socioeconomic health determinants.

This complex issue, with lifestyle a key aspect, has a long history and much has already been achieved. In the early twentieth century, lifestyle and measures to combat infectious diseases were high on the public agenda. On the initiative of various socially committed parties (employers, housing corporations), efforts were made to improve the way of life of ordinary workers. Nowadays, the main emphasis is on chronic diseases partly caused by lifestyle and the approach adopted is once again to offer effective initiatives tailored to specific needs. Effectiveness is enhanced by relevant social stakeholders making an effort to help people and motivate them to make use of the services available.

Various socioeconomic factors may entail additional health risks, including a lower level of education, lower income, poorer living and working environment and, in some cases, ethnic origin. The policy pursued at various levels of government is therefore based on the following principles:

- The Netherlands has a distorted socioeconomic health pattern, caused by a complex mixture of socioeconomic determinants. Easy access to health care, steadily improving levels of education and a good community approach are important prerequisites for reducing health disadvantages. Policy focuses primarily on these prerequisites.
- The quality of the everyday living and working environment contributes to health and has a major impact on people's ability to live a healthy life. This is partly the reason why the government, together with local authorities, is investing heavily to build strong communities in inner-city problem areas that combine a number of unfavourable factors and have a relatively high proportion of poorly educated and ethnic minority residents.
- The policies of six government departments also significantly contribute to reducing the impact of socioeconomic health determinants: Social Affairs and Employment (measures relating to poverty reduction, incapacity for work and working conditions); Education, Culture and Science (educational disadvantages, early school-leaving); Youth & Family (youth culture); Housing, Spatial Planning and the Environment (air quality), Agriculture, Nature and Food Quality (food quality); and Housing, Communities and Integration (public housing, Strong Communities Action Plan). Various social stakeholders are also involved, such as employers, local authorities, schools and housing corporations, which have a shared interest in and responsibility for the health of individuals and of society at large. The Ministry of Health, Welfare and Sport accordingly plans to urge these parties to maintain and strengthen their role in this area.
- As part of the Strong Communities Action Plan of the Minister of Housing, Communities and Integration, the government asked local authorities to specify how they intend to improve the health of residents in the 40 communities in question. Ten out of the 18 local authorities concerned have since indicated that they are planning to experiment with the concept of a healthy community in their problem areas. The aim of these experiments is to improve the health of residents in these communities by adopting an integrated approach focused on personal health, a healthy environment (including public areas and urban development) and coordinated primary health care, including preventive services. Over

the next few months the local authorities will draw up an action plan specifying how they will carry out these experiments.

The role of central government is to facilitate the task of local authorities wherever possible. This means identifying which initiatives are available and effective. The government will look at how the experience gained might be used to benefit other cities and regions.

f. The Committee asks for up-to-date information and statistics on access to care for the most disadvantaged groups.

The Dutch health system makes a distinction between cure and care: informal, primary, secondary and tertiary care and youth care, hospital care, care and treatment of addicts, care for the disabled and care for the elderly. Up to now the Netherlands has had no specific policy in the area of curative care (primary and secondary care) for people of low socioeconomic status (SES). Increasingly, however, attention is turning to the question of socioeconomic health differences, partly as a result of the prevention strategy presented in 2007. People who have low SES are in considerably poorer health than people who have high SES, which has prompted the Minister of Health, Welfare and Sport to draw up an action plan (due to be published towards the end of 2008) aimed at improving the health of the first group. The focus will be on prevention (promoting health), linking prevention and care and providing good-quality curative care for people who are disadvantaged.

Prevention at both national and local level is mainly aimed at specific risk groups in the population ('selective prevention'), such as smokers and people who are overweight, with information provided about diet and lack of exercise, smoking, sexuality, timely identification of gaps in health care, alcohol, drugs and leisure activities. There is every reason to also target preventive measures at people who have low SES, because their health is generally poorer, partly as a result of the aforementioned risk factors.

The type of resources used depend on the level at which they are targeted. At national level, options include lifestyle campaigns and health information, do's and don'ts (e.g. smoking ban in restaurants, cafés, bars and night clubs) and price measures (excise duty on alcohol).

g. The Committee asks for detailed information on the subject in the next report.

Hospital care must be accessible within what are known as the 'Treek norms', which are the maximum waiting times considered to be acceptable.

The Treek norms for 2008 have been set at:

- 4 weeks for access to an outpatient clinic
- 6 weeks for treatment in a daycare facility
- 7 weeks for treatment in more than one daycare facility

Type of care	Treek norm (in weeks)	% within norms (March 2008)
Outpatient clinic	4	81.07%
Daycare	6	84.90%
Multiple daycare	7	81.64%

Patients are free to consult the doctor of their choice. They – and health insurers – may freely choose a hospital based on their preferences and on waiting times. The waiting times are openly published on the internet. Insurers also act as an intermediary between patient and hospital to help find the shortest waiting time (*‘wachtlijstbemiddeling’*).

More than 80% of hospitals are accessible within the specified time limits (Treek norms), which means that in most of the cases hospital care can be provided nearby within the acceptable waiting time (the Netherlands has one of the highest hospital densities per capita in the world). It is the responsibility of the health insurers to guarantee sufficient supply in the healthcare industry and within their region. The right balance will be found in close collaboration with healthcare providers.

The above rules do not apply to emergency medical care or primary health care. Emergency medical care must always be provided immediately. There are no known structural problems in providing emergency medical care and primary health care on demand in the Netherlands.

Monitoring by the government shows that the system is working properly at the moment and that the Treek norms are being adequately met.

h. Health care professionals and facilities

The Committee notes that the situation, which it has previously considered to be compatible with the Charter (Conclusions XV-2, p.354-355) has not changed and asks for up-to-date facts and figures in the next report.

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

See answer to the European Committee of Social Rights’ first question.

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

Curative care aimed at remedying mental and somatic disorders is currently in a transition phase, switching from a budget-based funding model to a performance-based funding model, with the price, volume and quality of clearly defined care products being established by negotiation between health insurance companies and providers of curative care.

The transition entails greater risks for both care providers and health insurers, ensuring that all parties have an incentive to use their commercial and medical creativity to the full. This should lead to a better quality of care at a competitive price, where everyone concerned (including insured persons) has clear information about the price and quality of the care provided. In view of the public interest involved in health care, the government will continue to oversee accessibility, affordability and quality.

In 2005 a proportion of hospital care (approx. 10%) was funded through these care products for the first time, with insurance companies and hospitals having discretion to reach agreements on price. This percentage has now risen to more than 20% and, with plans to increase it further to about 33% by 2009, the goal is that performance-based funding should be the predominant model in health care within a few years. In the curative mental healthcare sector, the interested parties are currently considering which steps to take in 2009 and 2010 to introduce more performance-based funding.

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

Curative care in the Netherlands is divided into primary care (GPs and other health professionals that are accessible to patients without referral) and secondary care (specialists and outpatient treatment for which referral is required). To minimise costs, the current policy concentrates on strengthening primary care. If a primary care health professional cannot remedy a particular problem, the patient in question is referred to a specialist. Numbers of health professionals and facilities in primary and secondary care are detailed below.

Number of primary care providers (source: RIVM)

Family doctors: the average GP density in 2007 was 2,331 patients per full-time equivalent (FTE) GP, with only minor regional differences. There were fewest GPs in the central-eastern (Twente) and central-southern (Brabant) regions of the Netherlands (2,463 and 2,461 patients per FTE GP respectively).

Dentists: the average dentist density on 1 January 2006 was 2,728 patients per dentist.

Pharmacies: the Netherlands has 1,854 public pharmacies (2008 figure), an increase compared with 2004 (1,692).

Paramedics: on 1 January 2005 the average physiotherapist density was an estimated 1,330 patients per FTE physiotherapist. There are a total of 908 remedial therapists working in 688 practices (reference date June 2000). On 1 January 2006 there were 3,108 practising occupational therapists in the Netherlands.

Midwives: on 1 January 2007 the average midwife density was 1,665 women aged 15-39 per primary care midwife.

Number of medical specialists and hospital facilities (source: Ministry of Health, Welfare and Sport sectoral reports)

Medical specialists: the total number of registered medical specialists in 2003 was 16,077; the total number of practising medical specialists in 2002 was 11,774.

Hospitals: as of March 2007 there were 141 hospitals and 45 outpatient clinics, organised within 93 establishments, including eight teaching hospitals. Specialised hospitals and private clinics have been excluded (source: RIVM).

Specialised establishments: in 2007 the Netherlands had 98 specialised hospitals, organised within 62 establishments. The map shows the location of all 98 hospitals, some of which also have one or more outpatient clinics (also indicated on the map). There are 21 outpatient clinics in all. Like teaching and general hospitals, specialised establishments offer specialist medical treatment and nursing, but focus on specific types of diseases or categories of patients. Examples include rehabilitation centres and dialysis centres (source: RIVM).

Private clinics: the introduction of the Healthcare Institutions (Accreditation) Act on 1 January 2006 meant that private clinics no longer needed to be licensed by the Netherlands Board for Healthcare Institutions (CBZ). Instead, they must apply for unlicensed accreditation, which is granted on behalf of the Minister of Health, Welfare and Sport by one of the ministry's agencies, the Central Information Unit on Health Care Professions (CIBG). The CBZ issued 126 licences up to the end of 2005. Between 1 January 2006 and early 2007

the CIBG granted 49 accreditations. It is possible that a clinic may have received a licence or been granted accreditation, but is not yet operational. It remains registered, however, until the ministry receives notification of termination. Full details of the number of accreditations granted in 2007 by the CIBG are not yet available (source: RIVM).

Number of curative mental healthcare providers

Self-employed psychiatrists and psychotherapists: based on the membership of the professional organisation of psychiatrists and psychotherapists, there are an estimated 1,850 self-employed therapeutic mental health care providers.

Primary care psychologists: there are potentially 2,500 psychologists in the Netherlands, about 1,500 of whom are practising. Of these 1,500 practising psychologists, 1,305 are currently officially registered as primary care psychologists (including trainees) (source: Netherlands Institute for Health Services Research – NIVEL).

Psychiatric units in general and teaching hospitals: in 2004 there were 58 general hospitals with a psychiatric unit, compared with 43 in 2008 (source: RIVM and the Dutch Hospitals Association – NVZ).

Psychiatric university clinics: 7 of the 8 university medical centres in the Netherlands have a psychiatric university clinic (source: RIVM).

Paragraph 2

i. Encouraging individual responsibility

From among the activities carried out during the reference period, the Committee notes in particular the 2002 school health policy action programme of the Netherlands institute for health promotion and disease prevention (NIGZ) and asks to be informed about how the programme develops in practice.

Progress has been made on the initiatives taken in this area by the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ) on behalf of the Ministry of Health, Welfare and Sport. The coordinating role that the NIGZ had in developing the ‘Healthy School method’ was continued at national level from 1 June 2007 within the Healthy Lifestyle Centre (CGL) set up by the ministry. The CGL is a partnership between the RIVM, the nine health promotion organisations and the Municipal Health Services and has the task of matching supply and demand in the field of health promotion and ensuring initiatives are coordinated. This encompasses the Healthy School initiative, which is coordinated within the ‘Healthy School Environment’ programme. The Healthy School method is based on an American model and has been adapted to the Dutch situation as part of the ‘SchoolBeat’ (*SchoolSlag*) project, a demand-driven, coordinated regional approach to tailored school health promotion. Essentially this method enables schools to incorporate health into school policy, thereby ensuring a systematic approach to health issues. The emphasis is on maintaining and improving the physical, emotional and sexual health of children and adolescents aged between 4 and 18. Within the school environment, the health promotion organisations are working with a large number of Municipal Health Services to:

- continue developing the Healthy School method;
- monitor how this method is implemented nationwide;
- establish a coordinated and effective range of lifestyle initiatives for schools;
- help schools choose from the range of initiatives available.

The NIGZ is currently focusing on supporting professionals at local level. Furthermore, this Institute acquired the status of WHO Collaborating Centre for School Health Promotion at the end of 2007. Its main task in this context is coordinating the Schools for Health in Europe (SHE) network, which aims to draw attention to health in education and promote this issue in all 43 countries that are currently members of the SHE network. The task of coordination was taken over from WHO Euro in Copenhagen.

Paragraph 3

- j. *The Committee takes note of the information in the Netherlands report, and in particular the 2002-2006 health and environment action programme. It asks for information in the next report on practical initiatives under this programme.*

In the final report on the Action Programme, the National Environment and Health Action Plan, published in 2008, the key themes, aims and conclusions of the Programme are summarised. This summary is attached as Annex 5.

⇒ Annex 5: Summary of final report on the National Environment and Health Action Plan

- k. *Reduction of environmental risks*
The Committee refers to its previous conclusion for a general description of the situation regarding air pollution and ionising radiation (Conclusions XV-2, pp. 357), which it considered to be in conformity with the Charter. It asks for information in the next report on any changes in this area.

Air quality

The Netherlands did/will not comply with European standards for particulate matter (PM10) and nitrogen dioxide (NO₂) within the deadlines set by Europe: 1 January 2005 and 1 January 2010 respectively. However, the new European Directive published in June offers some latitude if we demonstrate that we can comply with the standards within an extended period of three years for particulate matter (2011) and five years for nitrogen dioxide (2015). To this end, the National Cooperation Programme on Air Quality was drawn up in 2008 and has now been submitted to the EU (by way of a request for derogation under the new Air Quality Directive). The Programme contains a large number of measures designed to considerably improve air quality and, assuming a derogation is granted, this should enable the Netherlands to go a long way towards achieving the standards for 2010 (NO₂ 100% by 2011 and PM10 almost 100% by 2010) and definitely achieve those for 2015 (NO₂ and PM10).

Radiation exposure

In the Netherlands the annual radiation dose per capita is relatively low (2.5 mSv) and has not changed substantially over the past 20 years.

- l. *Alcoholism – New restrictions came into force in November 2000. The number of sales outlets has been reduced, and young consumers must be required to produce proof of their age (16 for low-alcohol drinks and 18 for spirits). The Committee also notes the establishment of a new alcohol prevention organisation (STAP), which is working towards effective alcohol control policies and greater restrictions on advertising. It asks for information in the next report on new strategies for the 2001-2003 period, such as those proposed in the memorandum to Parliament in December 2000.*

In response to the plans outlined in the Alcohol policy document published in 2000, the following developments can be reported.

Public information

As planned, the interactive information provided to the public was stepped up during the period 2001-2003, at both national and regional level. Examples include the launch of a website to supplement a nationwide publicity campaign and the development of online self-tests, which give advice tailored to individual situations. Primary schools have also devoted more attention to the issue of alcohol prevention. A new curriculum has been developed, allowing more scope for creative ways of working and the use of modern media channels. Since research has shown that alcohol retailers are insufficiently familiar with the Licensing and Catering Act, a number of specific projects have been launched to educate this target group, aimed at both the commercial and the sports sector. For practical reasons, the plan to split the *sociale hygiëne* course did not come to fruition (this hospitality management course includes training on dealing with alcohol abuse).

Enforcement and sanctions

With regard to the intention to place more emphasis on enforcing legislation, the Inspectorate for Health Protection and Veterinary Public Health (KvW) appointed additional inspectors during the 2001-2003 period, which had a very positive effect. There was also much debate about the role of the police in this area, but this did not lead to new powers during the reference period. Administrative fines were introduced in 2005 under the Licensing and Catering Act, giving more scope for sanctions and speeding up response times. Furthermore, excise duty on alcohol was raised from 1 January 2003, which increased the price difference between soft drinks and alcoholic drinks. This conveyed a clearer message to young people wishing to buy alcohol, and also to heavy drinkers.

Permitted alcohol limits for drivers

The proposal to lower the legal blood alcohol limit to 20 mg per 100 ml for newly licensed drivers was implemented on 1 January 2006. The government has also explored the possibility of lowering the limit across the board, but no action has been taken because it would be too difficult to enforce.

Developments in the care and treatment of alcoholics

As planned, research has been carried out into patient flows within the addiction treatment and mental healthcare sectors. The experiment of opening addiction treatment centres in the evening was a success and has since been more widely introduced. The promised pilot scheme for children with alcohol-dependent parents was also set up and was successful. Preventive activities for children of alcoholics have since been stepped up and introduced in nearly every treatment centre. Furthermore, the announced project to improve the medical care provided for alcoholics went ahead, with significant results. This project had a dual aim: professional development and a protocol for addiction treatment. Lastly, a project bringing together AKZO-Nobel Chemicals, the local authority, welfare services and the police was developed with the aim of getting the business community more involved in coordinating local preventive activities.

Since the Alcohol policy document was published in 2000, new policy proposals have been developed and set out in the outline paper of 20 November 2007.

- m. *Drug addiction – The Committee asks for up-to-date information on the law and practice in the next report.*

The Netherlands has no drug addiction legislation. Addiction is primarily regarded as a health problem that has biological, psychological and social causes and consequences. Some drug addicts commit criminal acts or cause social nuisance. Dutch policy aimed at drug users seeks to prevent addiction leading to increasing health problems, degeneration, the spread of disease (through used needles, for instance), nuisance for other people and crime. The assistance provided is also intended to prevent addicts turning to a life of crime.

One of the primary objectives in helping addicts is abstinence. Another aim is to limit the damage caused by an addiction. Different kinds of treatment are available, ensuring that many addicts are reached.

Breaking a drug habit generally takes a long time, so it is important to work on stabilising the addiction if complete abstinence (at any given time) is not feasible. The aim is to reach as many addicts as possible. It is estimated that 70-80% of opiate addicts have sought treatment for their addiction. This has also provided insight into the scale of the problem, enabling policy to be adapted to reflect the actual situation. In the past few years the average age of opiate addicts receiving formal help has risen considerably and currently stands at 35. Care needs have also increased. Furthermore, it has been found that a large proportion of addicts in this group also suffer from psychiatric problems.

Half of clients in inpatient or outpatient addiction treatment programmes are opiate addicts. There are also clients with problems related to cocaine, cannabis and/or alcohol abuse. In 2004 there were an estimated 10,000 cocaine clients, 5,500 cannabis clients and 29,500 alcohol clients registered with addiction treatment centres. Almost 20% of the total number of clients in addiction treatment programmes were of ethnic minority origin.

- n. *To assess the effectiveness of policies relating to alcohol, tobacco and drugs policies the Committee needs statistics on trends in tobacco, alcohol and drug consumption. It therefore asks for detailed facts and figures in the next report on the results achieved.*

The 2007 National Drug Monitor provides facts and figures on the use of drugs, alcohol and tobacco. A summary of the findings is given below. More detailed information (in Dutch) can be found at: <http://www.minvws.nl/kamerstukken/vgp/2008/nationale-drug-monitor-2007.asp>.

Drugs: use and demand for treatment

Cannabis use: demand for treatment continues to rise

The percentage of current cannabis users in the general population aged 15-64 remained stable between 2001 and 2005. In 2005, 3.3% (i.e. 363,000 people) were current users. Contrasting with this stable trend, there has been a steady increase in the number of clients seeking addiction treatment for a cannabis problem. Between 1994 and 2006 the number of primary cannabis clients rose from 1,951 to 6,544, with a 7% increase between 2005 and 2006. Almost two-thirds of cannabis clients (63%) are 25 and over. Few people are admitted to general hospitals with cannabis problems as the primary diagnosis (54 admissions in 2006). The number of admissions with cannabis abuse and dependence as the secondary diagnosis is larger and rose from 299 in 2005 to 377 in 2006, an increase of 26%. This trend may indicate an increase in the number of problem users of cannabis, but may also reflect an improvement in the treatment available, or else a growing awareness of the addictive potential of cannabis, possibly prompting users to seek help sooner.

No further increase in cocaine treatment demand

Current use of cocaine in the general population aged 15-64 remained at the same level between 2001 and 2005 (in 2005: 0.3%, or 32,000 users). Among juveniles and young adults in social settings, cocaine use (mainly snorting) is considerably more prevalent than in the general population (3-19% current users in varying groups). Cocaine is used not only in the social scene, but often at home, both at the weekend and during the week. The popularity of this drug has now spread to all parts of the Netherlands, although – as in Amsterdam – saturation point seems to have been reached. There may have been a further rise in cocaine use among rural youth. Cocaine combined with alcohol continues to be the stimulant of choice. Among hard drug addicts, cocaine in the form of crack, which is smoked and is much more addictive, has become an established part of their drugs repertoire. Crack use occurs relatively seldom among problem juveniles. However, it is not known how many people suffer physical, mental or social problems on account of excessive cocaine use. Data from addiction treatment services registered a sharp rise in the number of primary cocaine clients from 2,500 in 1994 to 10,000 in 2004, but this trend did not continue in 2005 and 2006. In fact, there was a drop of 2% from 2005 to 2006 (9,599 cocaine clients), mainly due to a decrease in the number of clients with a primary crack problem. The number of hospital admissions involving cocaine showed an upward trend until 2002 and has fluctuated around the same level since then. In 2006 there were 514 admissions with cocaine abuse and dependence as the secondary diagnosis. Cocaine problems as the primary diagnosis occur much less frequently (90 admissions in 2006).

Increase in amphetamine clients, but numbers remain low

In the general population aged 15-64, amphetamine use is relatively low and stable. In 2005 the percentage of current amphetamine users was 0.2%, or 21,000 people. Nonetheless, the number of amphetamine users seeking addiction treatment more than doubled from 482 in 2001 to 1,215 in 2006. Between 2005 and 2006 there was an increase of 9%. The proportion of amphetamine users as a percentage of total treatment demand for drug problems is still low (4% in 2006). The number of general hospital admissions related to amphetamine-like substances is low, though 2004 brought a momentary rise in the number of secondary diagnoses in connection with amphetamine-like substance dependence and abuse (63 in 2003, 108 in 2004 and 88 in 2006). These trends in treatment demand may be linked with an increase in the number of problem users of amphetamine, but there are no statistics available to confirm this. Compared with cocaine and ecstasy, amphetamine plays a minor part in the social scene. Key observers do, however, report an increase in use in some parts of the country (north and south) and among some groups of young people, especially non-ethnic-minority youngsters living in rural areas, who sometimes use amphetamine as a cheaper alternative to cocaine.

Ecstasy use still popular, but seldom prompts demand for treatment

The percentage of current users of ecstasy in the general population remained stable between 2001 and 2005 (in 2005: 0.4%, or 40,000 users). In the nightlife scene, ecstasy is still a much-used drug, particularly at raves. Key observers report a moderation in ecstasy use, especially among slightly older clubbers. Excessive use is observed more often among new young users, although no trend statistics are available. The number of people seeking addiction treatment for a primary ecstasy problem has been low for many years and fell from 293 in 2005 to 228 in 2006. More than three times as many people report a secondary ecstasy problem (715 in 2006). Numerous studies suggest that frequent use of ecstasy causes changes to the serotonin receptors in the brain. Clinical effects of frequent ecstasy use have also been reported, such as memory loss and an increase in symptoms of depression. According to recent research, even

occasional use of ecstasy is not safe, although the effects of use in low doses on mental functioning are subtle.

Addiction treatment centres and hospitals report falling numbers of opiate users

According to the most recent estimates dating from 2001, there were between 24,000 and 46,000 problem opiate users in the Netherlands. Of the EU-15 member states, the Netherlands together with Greece and Germany has the smallest number of problem users per thousand inhabitants aged between 15 and 64 (2-3, compared with 8-9 in Italy and Spain, and 10 in the UK). The age profile of Dutch opiate users has grown steadily older over the years. The percentage of young opiate clients (aged 15-29) seeking addiction treatment fell from 39% in 1994 to 6% in 2005, remaining at the same level in 2006. Between 2001 and 2006 there was also a drop in the total number of clients with a primary opiate problem, from almost 18,000 to 13,000 (-22%). Between 2005 and 2006 there was a decrease of 7%. In 2006 only 4% of opiate clients sought help with a drug problem for the first time. The rest were already registered with the addiction treatment services. There was also a downward trend in the number of general hospital admissions with opiate problems as the secondary diagnosis: 594 and 476 in 2005 and 2006 respectively, a decrease of 20%. The remaining group of opiate clients is growing older and often has to contend with physical and mental problems. The decrease in the percentage of current injecting opiate clients registered with the addiction treatment services levelled off in 2005 and 2006 at 10%. New HIV diagnoses among injecting hard drug users are now rare. Injecting is still a significant risk factor for hepatitis C infection. The percentage of hepatitis C infections among registered HIV-positive injecting drug users is particularly high.

Article 12 – The right to social security

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

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

Article 12§1

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

a. Medical care

The Healthcare Insurance Act and the Healthcare Benefit Act were introduced on 1 January 2006. For information about the new healthcare system, please refer to the answers to the Committee's questions under Article 11.

List of current legislation (Acts and Decrees) governing medical care

- Exceptional Medical Expenses Act; Act of 14 December 1967 (Bulletin of Acts and Decrees 1992, 392), last amended by the Act of 13 December 2007 (Bulletin of Acts and Decrees 2007, 540)
- Royal Decree of 1 January 1999 (1999 Access to Social Insurance (Additional Categories of Persons) Decree) (Bulletin of Acts and Decrees 1998, 746)
- Healthcare Insurance Act; Act of 16 June 2005 (Bulletin of Acts and Decrees 2006, 79), last amended by the Act of 13 December 2007 (Bulletin of Acts and Decrees 2007, 540)
- Royal Decree of 28 June 2005 (Healthcare Insurance Decree) (Bulletin of Acts and Decrees 2005, 389)
- Healthcare Benefit Act, Act of 16 June 2005 (Bulletin of Acts and Decrees 2005, 369), last amended by the Act of 13 December 2007 (Bulletin of Acts and Decrees 2007, 540)

b. Child benefit (AKW)

No changes during the reporting period. For further information and the most recent child benefit rates, please see Part VII of the European Code report for the period from 1 July 2007 to 30 June 2008 (see annex 6).

⇒ Annex 6: European Code report for the period from 1 July 2007 to 30 June 2008.

c. Old age pension (AOW)

No changes during the reporting period. For further information and the most recent AOW rates, please see Part V of the European Code report for the period from 1 July 2007 to 30 June 2008 (annex 6).

d. Surviving dependants' pension (ANW)

No changes during the reporting period. For further information and the most recent ANW rates, please see Part X the European Code report for the period from 1 July 2007 to 30 June 2008 (annex 6).

e. Sickness benefit (ZW)

The Dutch Civil Code stipulates that employers must continue to pay at least 70% of sick employees' salaries for the first two years of their sick leave. For further information, see the European Code report for the period from 1 July 2007 to 30 June 2008 (annex 6).

f. Incapacity benefit (WAO/WIA)

The Invalidity Insurance Act (WAO) was replaced by the Work and Income (Capacity for Work) Act (WIA) on 1 January 2006. However, anyone in receipt of incapacity benefit on 31 December 2005 remains covered under the WAO. For further information concerning the WIA, see Part IX of the European Code Report for the period from 1 July 2005 to 30 June 2006 (see annex 7).

⇒ Annex 7: European Code report for the period from 1 July 2005 to 30 June 2006.

g. Unemployment benefit (WW)

For a chronological overview of the major changes that have occurred, please see the European Code report for the period from 1 July 2006 to 1 July 2007, pages 22/23/24.

⇒ Annex 8: European Code report for the period from 1 July 2007 to 30 June 2008.

Article 12§2

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

The Netherlands is bound by all parts of the European Code on Social Security, with the exception of Part VI, which the government denounced on 17 March 2008. This denunciation requires the formal approval of the Dutch Parliament. The House of Representatives has endorsed the denunciation of Part VI of the Code and has approved the Revised Code. The Senate has not yet decided whether to give its approval (date of report: 21 October 2008).

Article 12§3

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

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

See the answer given above under paragraph 1.

Article 12§4

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

During the reporting period new bilateral social security agreements were concluded with the following countries:

<u>Country</u>	<u>Date of entry into force</u>
Hong Kong	01-02-2005
Panama	01-03-2005
Poland	01-02-2005
Latvia	01-06-2005
Egypt	01-09-2005
Thailand	01-11-2005
Pakistan	01-12-2005
Jordan	01-04-2006
Belize	01-04-2006
Bulgaria	01-05-2006
Argentina	01-08-2006
Ecuador	01-11-2006
Former Yugoslav Republic of Macedonia	01-04-2007

Negative conclusions of the European Committee of Social Rights

- A. *The Committee concludes that the situation in the Netherlands is not in conformity with Article 12§1 of the Charter on the grounds that the information provided by the Government does not allow the Committee to assess that the right to sickness and invalidity benefits is effectively secured as a social security right for all workers.*

Under Dutch law, all employees and people of equivalent status, such as agency staff and home workers, are entitled to proper income protection in the event of sickness or incapacity for work. Income protection for sick people is guaranteed under both the Dutch Civil Code and the Sickness Benefits Act (ZW). Income protection in the case of incapacity for work is guaranteed under the Work and Income (Capacity for Work) Act (WIA). It can therefore be stated that the right to sickness and incapacity benefits in the Netherlands is effectively secured as a social security right for all workers. This point is explained in further detail below.

However, before dealing with the conclusion of the Committee, we would like to point out the following.

The WIA has now been in force for three years. It has been ascertained that the new employment disability system has been extremely successful so far. The following statistics illustrate this. The number of applications for benefits based on the WIA has halved in terms of its precursor, the Disablement Benefit Act or WAO, to use its Dutch acronym. This decline can be (partly) attributed to the extension from one to two years of the obligation to continue paying wages during illness, and to the greater responsibility of employers and employees towards reintegration.

Reducing the number of applications has led to a substantial decline in intake into the WIA compared to the WAO. Up to 2003, the WAO experienced an annual intake of around 100,000 people. A considerable decline then occurred within a couple of years. In 2006 and 2007, the intake was a little more than 20,000 people, and it is anticipated this will remain limited to around 24,000 people this year. All this leads to the total number of those who are work-disabled (WAO plus WIA) having decreased by some 200,000 people by the end of 2008 compared to 2002. The size of the pool (around 600,000 people) has therefore dropped to its lowest level in the last 25 years.

Of those who receive WIA benefits, the majority are completely work-disabled. Thus in 2007, 38,000 WIA benefits were paid, 31,000 of these for total employment disability. These people receive benefits of 70% to 75% of their daily wage. Half of the partially work-disabled occupy half of the remaining earning capacity. This means that at least 3,500 partially work-disabled people are working. This large number is partly the result of an increase in the number of reintegration trajectories employed by the UWV for the work-disabled. In addition, from 2006 there has been a significant increase in the number of people who are placed or reinstated with an employer as a result of the reintegration trajectories. In 2006 the placement percentage was around 30%, and has since then risen to 45% in the first quarter of 2008. This increase is presumed to have been caused partly by the favourable economic developments in recent years, and partly through the effects of learning. All in all, it may be concluded that the new employment disability system meets the expectation that it promotes the employment participation of those who are able to work.

This conclusion has recently been confirmed by the OECD in its report which examines the employment disability systems of four countries, including the Netherlands. The OECD praises the Netherlands because it has implemented the most fundamental changes to the sickness and employment disability regulations:

“When it comes to sickness and disability, no other OECD country has such an interesting story to tell as the Netherlands. First, sickness absence fell from 10% in the late 1980s to only 4% today. More recently, the inflow into disability benefit also dropped remarkably, from almost 12 per 1000 in 2001 (and in fact during most of the two decades prior to the turn of the century) to around four per 1000 in 2007. Eventually, from 2005 onwards, the total number of people on disability benefit also started to fall. This success is a consequence of a series of very comprehensive reforms, characterised by a shift of responsibilities to employers and employees, a tightening in benefit eligibility and generosity, and a (partial) privatisation of hitherto public schemes.”

Income protection in the event of sickness

In the event of sickness, employees within the meaning of the Dutch Civil Code are entitled to receive sick pay. By law, employers are required to continue paying sick employees 70% of their wages for a period of 104 weeks (Article 7:629, para. 1, Dutch Civil Code). The right to paid sick leave is a provision of preemptory law, meaning that the contract of employment

cannot provide otherwise to the detriment of the employee. It is, however, possible to deviate from this provision to the advantage of the employee, which is something that frequently occurs. Nearly all collective labour agreements stipulate that the employer shall pay more than the legally required 70% of wages to sick employees.

Not only salaried employees enjoy income protection while they are ill, but also people who may not work under a contract of employment, but have comparable status in light of their socioeconomic position. Examples include commercial agents, agency staff, home workers, artistes and elite athletes, who are entitled to sickness benefit, or sick pay, amounting to 70% of their daily wage for a period of 104 weeks. The amount and duration of their income protection is thus equal to the statutory income protection for salaried employees.

In this context it is important to note that the Sickness Benefits Act may also be relevant to employees, in that if a contract of employment comes to an end during the compulsory sick pay period, for example because the job was temporary, the employee continues to be entitled to sick pay. The amount is equivalent to 70% of the daily wage and is paid for a period of 104 weeks dating from the first day of illness. This means that employees on a short-term contract also have proper income protection for 104 weeks if they fall ill. This rule is also important for employees who are on sick leave when their contract of employment comes to an end in connection with their employer's bankruptcy. They, too, continue to receive sick pay equivalent to 70% of their daily wage for a period of 104 weeks dating from the first day of illness. On account of the above, the Sickness Benefits Act is said to serve as a safety net: every working person who is not entitled to continued payment of wages during sick leave is instead entitled to statutory sickness benefit. All things considered, it can be stated that the right to sickness benefit in the Netherlands is effectively secured.

Funding of income protection during sick leave

Employers are free to decide how they fund the risk of compulsory sick pay. They can either bear the risk themselves or place it with an insurance company. Most employers, some 80% of them, have opted for the latter, with the result that the risk of absence through sickness is largely funded under a group scheme. In other words, this risk is jointly spread over the employers that have placed their risk with the same insurance company. In effect, the funding of the sickness absence risk therefore mirrors the way in which benefit costs are funded in a social security system, i.e. by apportionment of the benefits among those who pay contributions. In this respect the changes that have occurred in the Netherlands since 1994, culminating in the present obligation on employers to continue paying wages during sick leave for 104 weeks, do not therefore constitute a break with the past. Under the Sickness Benefits Act, in the version valid until 1994, sickness benefits were also jointly funded by employers. Moreover, a system of differentiation in contributions was applicable (employers with a higher rate of sick leave paid higher contributions than employers with a lower rate of sick leave) and employers could also choose to bear the risk themselves. The current private method of funding sickness absence risk does not therefore differ fundamentally from a public funding method. In both cases employers pay the benefit costs, either directly (own risk coverage) or indirectly (via differentiated contributions). The only difference is that in a private funding system, employers can choose the insurance company with which they place their financial risk.

The Committee argues that one possible disadvantage of a private funding method is that employers try to reduce their sickness absence risk by selecting new recruits on the basis of their medical history. To prevent this, the Medical Examinations Act (WMK) was introduced in the Netherlands on 1 January 1998. Under this Act, employers may not require a pre-employment examination to be carried out, unless there are special requirements regarding

medical fitness for the job in question. One example might be working as a pilot. Research shows that the number of pre-employment examinations carried out in the Netherlands has fallen substantially. Several accompanying measures have also been taken to promote the recruitment or retention of people with a medical condition. For example, employers are entitled to a reduction in their social security contributions if they hire someone who is or has been incapacitated for work. Another advantage is that the Employee Insurance Agency (UWV) assumes the risk of continued payment of wages if an employer takes on or retains an employee with a medical condition. It can therefore be argued that privatisation of funding, combined with the introduction of the Medical Examinations Act and other accompanying measures, has increased rather than reduced the likelihood of workers with a medical condition being in employment.

Statutory sickness benefits are funded by means of contributions, which are raised by those for whom the insured perform work. A system of differentiation in contributions is in place, in which contributions differ according to sector (for example the temporary staffing sector), and employers can choose to provide for their own risk coverage. The contributions are fixed annually by the UWV. As argued above, this public funding method does not differ fundamentally from a private funding method

Income protection in the event of incapacity for work

Once the aforementioned period of 104 weeks has elapsed, salaried employees and working people of equivalent status (see above) are entitled to incapacity benefit under the Work and Income (Capacity for Work) Act (WIA) if their level of incapacity is at least 35%. The amount of benefit paid depends on the permanency and degree of incapacity.

In the case of permanent total incapacity, the insured is entitled to benefit amounting to 75% of his/her daily wage until the age of 65. In the case of non-permanent or non-total incapacity, known as partial incapacity for work, the insured is initially entitled to a wage-related benefit amounting to 70% of his/her daily wage. Wages are taken into account.

The period for which wage-related benefit is paid depends on previous employment, but it can be received for a maximum of 38 months. Thereafter the person concerned is entitled to either follow-up benefit (if unemployed) or a wage supplement (if in work).

The amount of follow-up benefit is related to the degree of incapacity and the statutory minimum wage. Where someone's level of incapacity is 50%, for example, the follow-up benefit is 35% of the statutory minimum wage. The amount of wage supplement is related to the degree of incapacity and the daily wage. Where someone's level of incapacity is 50%, for example, the follow-up benefit is 35% of the daily wage. Any income earned is not taken into account, unless the insured earns more than his/her remaining earning capacity, in which case the amount of wage supplement is equal to the wage-related benefit.

Since the categories of persons covered under the Work and Income (Capacity for Work) Act is the same as that under the Sickness Benefits Act, with a few exceptions, it can be stated that every worker in the Netherlands is entitled to proper income protection. As we have seen, the right to incapacity benefit is enshrined in law, as are the right to continued payment of wages and the right to sick pay. This right is exercised through the UWV, since it is this agency that determines entitlement to incapacity benefit and fixes the amount.

Funding of income protection in the event of incapacity for work

Statutory incapacity benefit is funded by means of a basic contribution and a differentiated contribution. The basic contribution is the same for all employers. It is used to fund benefits paid to people who are permanently totally incapacitated, as well as a proportion of the benefits paid to people who are partially incapacitated. The differentiated contribution for employers depends on their company's occupational disability risk. The higher the risk (i.e.

the more employees there are who are incapacitated for work), the higher the contribution. This differentiated contribution is used to fund the remaining proportion of benefits paid to people who are partially incapacitated. As was the case under the Sickness Benefits Act, employers can choose to provide for their own risk coverage. In this case, they do not have to pay differentiated contributions; instead they or their private insurance company bear the full cost of the benefits paid to partially incapacitated people who are or were in their employment. The Work and Income (Capacity for Work) Act and the Sickness Benefits Act are therefore funded in very similar ways.

The final point worth making here is that the Work and Social Assistance Act (WWB) provides every person residing legally on Dutch territory with a guaranteed minimum income equivalent to the subsistence level. For this reason, it can be stated that the Netherlands complies with the obligations of Article 12, para. 1.

B. The Committee concludes that the situation in the Netherlands is not in conformity with Article 12§3 of the Charter on the grounds that self-employed persons are no longer covered by the sickness, maternity and invalidity branches of the social security system.

The Netherlands' response to this conclusion is as follows. The Invalidity Insurance (Self-employed Persons) Act (WAZ) was introduced on 1 January 1998 (which, together with the Invalidity Insurance (Young Disabled Persons) Act (WAJONG), replaced the General Invalidity Benefits Act (AAW)). This new legislation provided for a minimum level of compulsory public incapacity insurance for self-employed people. Self-employed women insured under this Act were also entitled to maternity benefit.

Access to this Act was barred as of 1 August 2004, prompted by closer consideration of the need for and desirability of compulsory public insurance. This exercise involved examining developments since the Act had come into force and analysing the effects of repealing it. Based on its findings, the government of the day came to the conclusion that – partly at the request of organisations representing self-employed people – compulsory public insurance for the self-employed was not required. The self-employed did not need this kind of incapacity insurance to be provided through this particular legislative channel. The weighting of premiums based on income was perceived as excessive and the premiums were considered too high. Entrepreneurship, with the opportunities and risks it entails, is a conscious career move for this group, and one aspect is that they want to be able to decide for themselves whether and to what extent they wish to insure themselves against the risk of occupational disability. Furthermore, a satisfactory alternative to public insurance was (and still is) available in the form of private cover. Against this background it was decided to repeal the Invalidity Insurance (Self-employed Persons) Act.

Since the repeal of this Act, self-employed individuals have been able to choose whether or not to insure themselves against the risk of occupational disability. The government also ensures that those wishing to insure themselves against the consequences for income of being incapacitated for work have access to a sufficient range of options:

1. The self-employed can take out private insurance against the risk of occupational disability. Several insurance companies offer various incapacity insurance policies for this group. The products differ in terms of policy conditions and price. In that sense, there are now more insurance options compared with the period when the Invalidity Insurance (Self-employed Persons) Act was in effect and only uniform compulsory insurance was available.

2. In addition – at the government’s request – private insurers offer ‘safety net’ insurance, specifically intended to cover risks that are difficult to insure. This affects self-employed individuals who, because of their higher risk, cannot take out ‘ordinary’ incapacity insurance, for example because they have been turned down by an insurance company or are only accepted subject to premium supplements and/or exclusions.
3. Besides the options available in the private market, employees or former employees wishing to become self-employed can also voluntarily continue to be insured against occupational disability under the Sickness Benefits Act, the Invalidity Insurance Act or the Work and Income (Capacity for Work) Act.

The government has taken measures to ensure that self-employed individuals are effectively able to take out private insurance if they so wish:

- at the government’s request, insurance companies have developed a ‘safety net’ insurance policy for self-employed individuals who are difficult to insure;
- people who were in employment or on benefit before becoming self-employed have the option of continuing with the compulsory public insurance scheme when they turn self-employed (opting in).

Research shows that almost half of all self-employed people have insured themselves privately against the financial consequences of being incapacitated for work; the remainder are not insured.

In this context it should be noted that any uninsured self-employed person who becomes incapacitated for work and has no other source of income can fall back on the safety net of the Work and Social Assistance Act.

The final point that the Dutch government would like to make here is that the Self-Employment and Pregnancy scheme came into effect on 4 June 2008, under which self-employed women are entitled to maternity benefit for at least 16 weeks.

The Dutch government is therefore of the opinion that the requirements of Article 12, para. 3 have been met.

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

In accordance with Article 21-1§3 of the Committee’s Rules of Procedure, a dissenting opinion by Mr Jean- Michel BELORGEY, joined by Mr Nikitas ALIPRANTIS, Mrs Csilla KOLLONAY-LEHOCZKY and Mr Lucien FRANÇOIS, is appended to these conclusions. A dissenting opinion by Mr Tekin AKILLIOGLU is also appended

The Dutch government shares the Committee’s view that the movement of workers should not be impeded by a loss of social security rights, such as accrued pension benefits, for example. The framework within which the Netherlands has undertaken binding agreements (via the Charter or, for example, the EC Treaty) is irrelevant: accrued social security rights are exported to the Contracting Parties. With regard to the Committee’s opinion on the export obligation under the Social Security Supplements Act, however, the Dutch government takes a different view and would like to make the following comments.

The Social Security Supplements Act prohibits the export of supplementary benefits. The ban stems from the fact that this kind of benefit is a social security provision that is paid for out of central funds. Furthermore, the amount of the supplementary benefit is adjusted to the amount of the Dutch guaranteed minimum income. The Social Security Supplements Act is thus closely linked with socioeconomic circumstances in the Netherlands. The Dutch government feels that it is inappropriate to respect the right to supplementary benefits of people who do not live in the Netherlands and therefore no longer have close ties with this country. In this context it should also be pointed out that the export ban in the aforementioned legislation has not been made dependent on the existence of any bilateral social security agreements. Nor is any distinction made between Dutch nationals and third country nationals; benefit claimants cannot export supplementary benefits if they leave the Netherlands to take up residence abroad.

The Dutch government does not dispute the Committee's opinion that the Social Security Supplements Act is a social security provision that supplements employee insurance. The fact that supplementary benefits cannot be exported does not, however, affect the underlying loss-of-income benefit. The people concerned do not, therefore, lose their entire income as a result of the export ban, only the portion equivalent to the difference between the amount of their benefit and the Dutch guaranteed minimum income (if the latter is higher).

Unlike the Committee, the Dutch government is of the opinion that, under the Charter, it is not obliged to export supplementary benefits under the Social Security Supplements Act and accordingly advances the following arguments. The Charter contains no material provisions pertaining to the social security benefits that come under the Charter. Article 12 of the Charter concerns solely the right to social security. The individual paragraphs of Article 12 contain general objectives with which a Contracting Party must comply. All in all, it is not apparent from Article 12 of the Charter that the Netherlands is obliged to export supplementary benefits under the Social Security Supplements Act.

Unlike the Charter, European Community law includes explicit provisions concerning social security. The EC Treaty, specifically Article 42, stipulates that arrangements be made to secure for migrant workers the payment of benefits. These arrangements are worked out more fully in Regulation (EEC) No. 1408/71 (hereafter Regulation 1408). Regulation 1408 contains an explicit provision identifying the social security branches to which this Regulation applies and an explicit provision concerning the relationship between benefit and place of residence or, where appropriate, an export obligation in relation to specific benefits. The Netherlands regards the Social Security Supplements Act as a social security scheme that comes under Article 4 of Regulation 1408. This certainly does not mean that supplementary benefits under the Act need to be exported within the European Union. Article 10a of Regulation 1408 stipulates that the export provision does not apply to special non-contributory benefits. Benefit claimants receive these benefits exclusively in the territory of the Member State in which they reside, in accordance with the legislation of that State, provided that such benefits are listed in Annexe IIa. The Community legislature included the Social Security Supplements Act in Annexe IIa with effect from May 2005. It follows that benefit claimants who have taken up residence outside the Netherlands lose their right to supplementary benefits under the Act as long as they no longer reside in the Netherlands. However, the underlying loss-of-income benefit can be exported without further conditions.

The Dutch government takes the view that it is not liable under the Charter to start exporting supplementary benefits under the Social Security Supplements Act, given that the scope of Article 12 is extremely general, where European Community law provides for a very detailed

export obligation in Regulation 1408 with the possibility of exceptions, provided that the benefits in question are special non-contributory benefits.

The government therefore takes the view that the requirements of Article 12, para. 4 have been met.

Questions from the European Committee of Social Rights arising from the Netherlands' previous report (18th)

- a. *The Committee asks the next report to provide figures, for the period of reference, for every branch in percentages in order to be able to assess the effective coverage of the total population (health care, sickness insurance and family benefits) or of the active population (sickness and maternity benefits, unemployment benefits, pensions, and work accidents or occupational diseases benefits).*

National insurances

Table 12.1 Child benefit

	2005	2006	2007
Number of benefit claimants (year-end)	1,930,000	1,933,000	1,930,000
Insured persons	16,305,000	16,334,000	16,404,000

Explanation of child benefit:

In the Netherlands, all parents are entitled to child benefit on behalf of their own children or step-children under the age of 18. The rate of coverage is (by definition) 100%. In 2007, 1,930,000 parents were entitled to child benefit. The number of child benefit claimants appears to have remained fairly constant over the past few years.

Tabel 12.2 Old age pension

	2005	2006	2007
Number of pension claimants (year-end)	2,554,000	2,605,000	2,664,000
Insured persons	11,008,000	11,019,000	11,039,000

Explanation of old age pension:

- Old age pension is an accrued insurance scheme, meaning that the group of people who are insured under the General Old Age Pensions Act (AOW) and accumulate rights are not the same group of people that actually receive old age pension.
- Everyone between the ages of 15 and 65 living in the Netherlands (11,039,000 people in 2007) is insured under the General Old Age Pensions Act. This means that they accrue 2% old age pension rights annually. People younger than 15 or older than 65 do not accrue these rights.
- Everyone over the age of 65 living in the Netherlands receives old age pension, provided they have accrued pension rights in the preceding years. At the end of 2007, 2,664,000 people aged 65 and over were in receipt of old age pension.
- Anyone who is not entitled to a full old age pension and has little or no private pension, resulting in his/her income falling below subsistence level, can make a claim under the Work and Social Assistance Act (WWB).
- The number of old age pension claimants has risen by about 50,000 on a yearly basis in recent years, which is an annual increase of about 2%.

Employee insurances*Table 12.3 Sickness benefits*

	2005	2006	2007
Number of claims paid out	473,000	656,000	621,000
Insured persons	6,130,000	6,194,000	6,334,000

Explanation of sickness benefits:

In the event of sickness, employees within the meaning of the Dutch Civil Code are entitled to receive sick pay from their employer. Workers without an employer, e.g. temporary workers, are entitled to benefit under the Sickness Benefits Act (see also answers relating to sickness and incapacity for work system). The number of new sickness benefit claimants in any given year fluctuates and has been over 600,000 for the past two years.

*Incapacity benefits**Table 12.4 Work and Income (Capacity for Work) Act (WIA) / Invalidity Insurance Act (WAO)*

	2005	2006	2007
WAO incapacity benefit claimants (year-end)	703,000	639,000	596,000
WIA incapacity benefit claimants (year-end)	-	19,000	38,000
Total benefit claimants (year-end)	703,000	658,000	634,000
Insured persons	6,130,000	6,194,000	6,334,000

Explanation of WIA/WAO

New legislation governing incapacity for work was introduced in 2006 in the form of the Work and Income (Capacity for Work) Act (WIA), which replaced the Invalidity Insurance Act (WAO). Since then there have been no new incapacity benefit claims under the WAO, with the result that numbers are falling year on year. On balance, the total number of incapacity benefit claimants (WAO + WIA) has declined by about 10% since 2005.

Table 12.5 Invalidity Insurance (Young Disabled Persons) Act (WAJONG)

	2005	2006	2007
Number of benefit claimants (year-end)	147,000	156,000	167,000
Insured persons	11,008,000	11,019,000	11,039,000

Explanation WAJONG

- The Invalidity Insurance (Young Disabled Persons) Act provides for incapacity benefit for young disabled persons: people who are already partially or fully unfit for work before they enter the labour market.
- In the past few years the number of people claiming this incapacity benefit has risen by about 10,000 on an annual basis. The growth of the Wajong is worrying. The Dutch government is working on measures in order to reduce this growth, by making it easier and more profitable for Wajongers to work. Employer's organisations want the government to also take measures that reduce the number of people that are diagnosed Wajong.

Table 12.6 Invalidity Insurance (Self-employed Persons) Act (WAZ)

	2005	2006	2007
Number of benefit claimants (year-end)	53,000	47,000	43,000
Self-employed persons	816,000	879,000	965,000

Explanation WAZ:

- The Invalidity Insurance (Self-employed Persons) Act provides for incapacity benefit for self-employed people who are unfit for work.
- This Act was repealed on 1 August 2004 (see also under e) in respect of new claimants. The number of claimants has therefore been falling steadily since 2005.

Table 12.7 Unemployment benefits

	2005	2006	2007
New unemployment benefit claimants	376,000	311,000	252,000
Insured persons	6,130,000	6,194,000	6,334,000

Explanation of unemployment benefits:

- The number of new claimants has fallen substantially in the past few years, mainly as a result of the economic boom.
- Some changes were also made to the Unemployment Insurance Act (WW) in 2004: the period for which the benefit was paid out was significantly curtailed and access was tightened up.

- b. *The Committee wishes to have a more complete picture of the workings of the new funding system and notably of the safeguards that have been implemented or are under consideration with a view to mitigating any negative effects of the privatized funding system”.*

See the answer to the first negative conclusion in this Article.

Table 12.8 Contributions

Contributions as of 1 July 2008	National insurance schemes (Contributions remitted to the tax authorities)		
	AOW*	ANW*	AWBZ*
Employer	-	-	-
Employee	17.90	1.10	12.15

* AOW: old age pension

* ANW: surviving dependants' pension

* AWBZ: exceptional medical expenses

The contributions are levies on taxable income derived from work and one's own home in a lump sum, together with salaries tax. A standard income tax deduction applies to everybody. Various tax credits are available depending on the individual's situation.

Contributions as of 1 July 2008	Employee insurance schemes (<i>contributions remitted to the tax authorities</i>)						
	WAO/WIA* basic contribution	WAO* uniform standard contribution	WGA* differentiated, standard contribution	WW* (AWF*) 1)	WW* (sector funds)	KO* compulsory contribution for childcare	ZVW*
Employer	5.65	0.15	0.57	4.75	1.02 ²⁾	0.34	7.20
Employee	-	-	-	3.50	-	-	-

- *WAO/WIA: incapacity benefits;
- * WGA: work resumption benefit for persons partially capable of work;
- * WW: unemployment benefit;
- * AWF: General Unemployment Fund;
- * KO: childcare;
- * ZVW: healthcare insurance

¹⁾ AWF marginal contribution percentage starting from a contribution-free allowance of €61 a day

²⁾ Average sector contribution

The maximum income assessable for national insurance schemes is € 177.03 per day (€ 46,204.83 on an annual basis). The General Child Benefits Act (AKW) is funded from general taxation.

- c. *The Committee asks whether the combination of these two systems means the entire working population is covered.*

See the answer to the first negative conclusion in this Article.

- d. *The Committee asks what “suitable” employment means and requests information on whether there is an initial period where jobseekers may refuse to take up an offer of a job on the grounds that it does not meet his/her occupational requirements or experience without risking losing his/her unemployment benefits.*

See attached report on the European Code, reporting period 1 July 2005 to 1 July 2006, pages 18/19/20, “culpable unemployed”/ “predominantly to blame for his or her unemployment”. The Dutch government also refers the Committee to the European Code report, reporting period 1 July 2006 to 1 July 2007, pages 22/23/24, and to the court cases concerning the Unemployment Insurance Act (WW), which were sent to the Committee separately as an annexe to the European Code report for the period 1 July 2007 to 30 June 2008.

Paragraph 3

- e. *The Committee asks the next report to provide further information on the abolishment of the Disablement Benefits (Self-Employed Persons) Act (WAZ) and its consequence according to the above criteria.*

See the answer to the second negative conclusion in this Article.

- f. *The Committee asks whether social security benefits are re-adjusted yearly taking into account developments in wages, prices, and the economy.*

The Dutch government confirms that social security benefits are, in principle, re-adjusted yearly, and in some cases even half-yearly. Under the provisions of the Surviving Dependants Act (ANW), the General Old Age Pensions Act (AOW), the Sickness Benefits Act (ZW), the Work and Income (Capacity for Work) Act (WIA), the Unemployment Insurance Act (WW) and the Invalidity Insurance Act (WAO), the rates are adjusted whenever the rate of the minimum wage (with regard to the AOW and ANW) and/or the rate of the daily wage (with regard to the ZW/WW/WIA/WAO) is adjusted. Under the provisions of Article 14, para. 5, the rate of the minimum wage is adjusted every six months on 1 January and 1 July.

Paragraph 4 – Social security of persons moving between states

- g. *The Committee asks the next report to provide information about the extension in practice of the equal treatment principle to the third country nationals.*

Dutch national social security legislation does not make any distinction between nationals and third country nationals. Regulation (EEC) No. 1408/71 and Regulation (EEC) No. 574/72 are, in this case, irrelevant. In this context, see also the answer to the third negative conclusion.

- h. *The Committee asks for information on Georgia.*

There are no definite plans to conclude a bilateral agreement with Georgia, or with the other two countries mentioned, Moldova and Armenia.

- i. *Considering that the full old-age pension corresponds to the minimum statutory wage, this means that migrants are entitled to pensions which risk being lower than the poverty threshold. The Committee asks the next report to provide information on the measures planned to redress the situation.*

In relation to this question, the Dutch government refers the Committee to the Direct Request, Part III “Concerning Old Age Benefits”, the Annexe to the European Code report for the period 1 July 2007 to 30 June 2008.

⇒ Annex 9: Direct Request, Part III “Concerning Old Age Benefits”, the Annexe to the European Code report for the period 1 July 2007 to 30 June 2008.

- j. *The Committee renews its question on what measures, unilateral or otherwise, the Government intends to take if bilateral agreements ensuring the retention of accrued benefits have not entered into force for all the parties to the Charter or to the Revised Charter upon the expiry of the transitional period.*

Several new benefit restrictions agreements have been concluded: see the list under paragraph 4 of this Article.

The General Old Age Pensions Act (AOW) is exempted from the export restrictions under the Export of Benefits (Restrictions) Act (BEU). Anyone who takes up residence in a non-treaty country will remain entitled to a maximum pension equal to 50% of the net statutory minimum wage. A single person entitled to a pension will receive a maximum pension of 50% instead of 70% of the net statutory minimum wage.

However, anyone already receiving a pension abroad on 1 January 2000 will continue to do so.

Article 13 – The right to social and medical assistance

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

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

Article 13§1

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

Medical care

Anyone in the Netherlands who requires medical care will receive it. Since 1 January 2006, when the Healthcare Insurance Act (*Zorgverzekeringswet*) and the Healthcare Benefit Act (*Wet op de zorgtoeslag*) came into force, all persons lawfully resident in the Netherlands have been required by law to take out healthcare insurance. Healthcare insurers are obliged to accept anyone who applies for insurance, and may not alter the nominal premium to reflect a person's age or state of health. The healthcare benefit system is in place to cover the gap if the nominal premium (which people pay directly to the healthcare insurer they have chosen) is excessively disproportionate to a person's income. In principle, people on low incomes in the Netherlands should therefore be able to meet the nominal contribution.

Nevertheless, there may be situations resulting from personal circumstances in which a person cannot pay, or is no longer able to pay. Such personal circumstances could include social problems, problematic debts or mental illness. Although it is not possible to cancel healthcare insurance, the healthcare insurer can advise the person in question on getting social or financial assistance. Municipalities can choose to provide vulnerable groups with special social assistance which will enable them to pay the nominal contribution. They can also set up special collective insurance agreements with health insurers for those entitled to social assistance benefit, and for others on low incomes, and arrange payment of the contributions.

Social assistance

There have been no new developments affecting the Work and Social Assistance Act (WWB) since the previous report.

Long-term minimum-income allowance

As of 1 January 2009 the long-term minimum-income allowance will be decentralised. This means that the provisions governing the granting of long-term minimum-income allowance will be determined by municipalities themselves instead of the national authorities.

In doing so the government wants to give municipalities more scope to tailor solutions to individual needs, in a way that will not discourage people from taking up work or improving their income. Under the current system there are few opportunities for doing this. Municipalities pay out the long-term minimum-income allowance to people on a minimum income who have limited assets and no prospects of getting a job. The municipalities have to draw up regulations in a new bye-law determining the amount to be paid out, and defining the terms long-term, low income () and no prospects of getting a job. The long-term minimum-income allowance will become a special form of categorial crisis payment.

The allowance is currently only available to people who receive benefits. Under the new system, people who have paid work but have lived on the minimum wage for a long time and have no prospect of improving their income will also be eligible, as will those receiving social assistance benefit who begin working for a minimum income. The bill will come into force on 1 January 2009, once it has been approved by the House of Representatives and the Senate.

Table 13.1: Annual long-term minimum-income allowance

LONG-TERM MINIMUM-INCOME ALLOWANCE	2007	2008
Single people	€ 336	€ 341
Single parents	€ 430	€ 436
Married/cohabiting couples	€ 478	€ 486

Table 13.2: Total volume of long-term minimum-income allowance, in millions of euros

	2005	2006	2007
Long-term minimum-income allowance	40.2	41.6	N/A

In 2005 more than 85,000 households received a long-term minimum-income allowance.

Table 13.3: Standard social assistance benefit as of 1 January 2008

STandard social assistance benefit	AMOUNT
Single people	€ 630.14* net per month, including holiday allowance
Single parents	€ 882.20* net per month, including holiday allowance
Married/cohabiting couples	€ 1260.28 net per month, including holiday allowance

* Single people and single parents are eligible for a maximum allowance of €252.06 net per month (20% of the net minimum wage) on top of this if they cannot share living costs, e.g. accommodation costs, with anyone else.

Table 13.4: Number of social assistance benefit payments

	AT YEAR- END 2005	AT YEAR- END 2006	AT YEAR- END 2007
Number of social assistance benefit claimants	328,000	301,000	274,000

Source: Statistics Netherlands (CBS)

Table 13.5: Number of crisis payments made, in millions of euros

	2005	2006	2007
Crisis payments	316	143	177

After the WWB was introduced in 2004 the number of social assistance benefits fell by 10% within two years. Research has shown that 4% of this can be attributed to the WWB. Since the introduction of the WWB, the number of new social assistance benefit claimants has fallen by 19%, while the number of ex-claimants has risen by 23%. And the trend is continuing. As shown in table 13.4, by the end of 2007 the number of people claiming social assistance benefit had fallen to 274,000. The number of ex-claimants successfully completing reintegration schemes and finding work (gross effectiveness) has clearly increased since the WWB was introduced, from 10% to 19%³.

Article 13§2

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

There have been no new developments.

Article 13§3

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

The guiding principle of the Work and Social Assistance Act (WWB) is that it is people's own responsibility to do all they can to provide for themselves. They are only eligible for help from the government if they are unable to do so. Under the WWB, municipalities are responsible for providing this help.

The Centre for Work and Income (CWI) can help people who are unable to support themselves to find work. If they are unable to do so, they can apply to the CWI for benefits.

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

There are around 150 CWIs located throughout the Netherlands. Each branch provides public employment services, including administrative intake, collecting data on the labour market,

³ 'Is the WWB working?' (*Werkt de WWB?*), a study commissioned by the Ministry of Social Affairs and Employment and carried out by Meccano Policy research together with the University of Twente and BSZ Beleidsonderzoek.

providing information and advice, and mediating. The CWI is also responsible for collecting information required for processing benefit applications. As many job vacancies as possible are offered through the CWI, which also has free internet access for jobseekers. The CWI provides information on different professions and training opportunities and, in addition to self-service options, can offer sessions with reintegration coaches and employment advisers if required.

The CWI has a website, www.werk.nl, where jobseekers can browse thousands of vacancies and apply for benefits online. The CWI also organises a national job fair, offering thousands of vacancies at almost 100 locations throughout the Netherlands.

Social Counsels can assist people who need help applying for benefits. The Social Counsel Network (SRW) provides free advice and information on the legal aspects of social assistance to people who find it difficult dealing with rules and regulations and official bodies. The emphasis is on helping the most vulnerable, for example people with a poor educational background and/or on a low income, and people who are otherwise unable to help themselves. The kind of help offered is very practical, e.g. helping people to draft a letter or notice of objection.

Sites such as www.berekenuwrecht.nl and www.toeslagen.nl, where people can calculate what they are entitled to, are also available.

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

In 2007 www.werk.nl, which offers links to 114 job vacancy sites and 84 employment agencies, had around 40,000 individual visitors every day.

In total some 495,000 jobseekers approached the CWI for unemployment or social assistance benefits. Some 143,000 new CWI clients did not need to apply for benefits, thanks to the help they received.

The SRW has offices in some 80 different institutions. On average, the SRW receives more than 500,000 questions on an annual basis, which are dealt with in 400,000 contacts with clients.

Article 13§4

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

Under the Healthcare Insurance Act (*Zorgverzekeringswet*) all persons lawfully resident in the Netherlands are insured under the Healthcare Benefit Act (*Wet op de zorgtoeslag*) and the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*), regardless of nationality. Persons who are not lawfully resident in the Netherlands are excluded from social insurance. This includes the social health insurance provided for under the Healthcare Insurance Act and Exceptional Medical Expenses Act.

Persons who are uninsured will receive necessary medical care, even if they are not lawfully resident in the Netherlands. This is because healthcare providers have a moral and professional obligation to provide adequate medical care, even if a person has no health insurance and is unable to pay the costs.

There have been no new developments in terms of social assistance.

Questions from the European Committee of Social Rights in response to the Netherlands' previous (18th) report

Paragraph 1

a. *The Committee understands that the basic financial assistance may be topped up by the long-term minimum-income allowance or the crisis payments. It asks whether this interpretation is correct.*

The interpretation is correct. See also under Article 13§1.

b. *The Committee therefore asks for details in the next report on how the arrangements work in practice, what conditions offers of employment must meet and what reasons for refusing an offer are acceptable. It also asks what form the penalties take and whether there is a right of appeal to an independent body against such decisions.*

The entitlement to social assistance benefit is always linked to the recipient's obligation to seek work so that benefit is no longer required. This means that the level of benefit received depends not only on the applicable standard benefit amount and the means of the individual concerned, but also on the extent to which they meet obligations to which they are subject. When an application for social assistance is made the municipality makes it clear to the applicant what their obligations are, and what the direct consequences will be if one or more of them are not met. The municipality itself determines the consequences.

Under the WWB everyone, in principle and to the best of their ability, should acquire or take up generally accepted work. The term 'generally accepted work' means work which is acceptable in mainstream society. Given its safety-net character, the guiding principle of the WWB is to keep the path to work as short as possible. Accordingly, people should be willing to accept any form of work they can get. Benefit applicants cannot demand that work reflects their level of education, previous work experience or salary expectations. This means they may need to accept work below their 'level'. Activities which are not acceptable in mainstream society, such as prostitution, are excluded, as are activities that compromise people's integrity, such as work that could raise conscientious objections. Not setting limiting conditions on the nature and scope of the work, and its relevance to education and experience, reduces the need for income support as much as possible.

People's individual capacity, in terms of their capabilities and state of health, does of course need to be taken into consideration. There is, therefore, room for the municipality to assess each case individually. The municipality may even choose to exempt the social assistance benefit claimant from the requirement to work, temporarily or permanently. Municipalities should exercise caution in enforcing the requirement to work. They should not compel people to apply for jobs or make other efforts where this serves no purpose. If there are really no prospects of acquiring paid work, an exemption from the requirement to work would be the

obvious option. At the end of 2006, 26% of social assistance benefit claimants were exempt from applying for jobs because of psychological or physical impediments or other obstacles. It is difficult to say how many people can be categorised as unemployable. Social services directors have estimated that around 35% of social assistance benefit claimants fall into this category.

Councils can also choose to offer claimants an employment contract instead of benefits.

The municipality imposes sanctions on social assistance benefit claimants who do not keep to the rules, either by imposing a measure or issuing a written warning. The municipality is responsible for determining its own sanctions policy, which must be set out in a bye-law. No reduction will be imposed in the absence of any form of culpability. Moreover, the municipality can take personal circumstances and individual obligations into account when determining the reduction.

Any sanctions imposed are always laid down in a decision. Any decision may be challenged by a notice of objection and an application for review. A clause to this effect is included in the decision. The person subject to sanctions may always challenge a decision made by the municipality. He or she must submit the notice of objection, in writing, within 6 weeks of receiving the decision. If the person in question does not agree with the outcome of the objection, he or she can apply for review to a court within 6 weeks. No lawyer is required. He or she may then submit an appeal against the court's decision to the Central Appeals Court for Public Service and Social Security Matters (*Centrale Raad van Beroep*).

- c. *Turning to medical assistance, in the case of persons who are compulsorily insured under the Health Insurance Act (Ziekenfondswet, ZFW), the municipalities meet the cost of the fixed or "nominal" insurance premiums. Under the ABW Act, compulsorily uninsured persons were entitled to reimbursement (as crisis payments) of private medical insurance costs covering the same risks as compulsory insurance. The Committee asks how the new WWB Act safeguards the right to medical insurance for persons not affiliated to the compulsory health insurance scheme.*

Since 1 January 2006 all persons lawfully resident in the Netherlands have been insured through the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten) and are obliged to be insured under the Healthcare Insurance Act (Zorgverzekeringswet). Healthcare insurers are obliged to accept anyone who applies for healthcare insurance, including social assistance benefit claimants (ban on risk selection). Anyone who does not pay their premium may, however, end up uninsured. Everyone with a minimum income is entitled to an allowance to help cover the nominal health insurance premium (healthcare benefit). Care providers faced with an acute medical emergency are, however, obliged to provide certain emergency services, even if the person requiring treatment is uninsured. Municipalities can also offer persons aged 18 or over 'crisis payments' in the form of collective health insurance (including supplementary cover). This also allows them to arrange discounts for social assistance benefit claimants. Moreover, the municipality can make crisis payments available to people who have individual supplementary insurance, to cover vital costs not provided for by the insurance.

- d. *supplementary benefits:*
i. *as noted above, depending on individual circumstances, a monthly sum of up to 20% of the minimum wage may be granted, that is € 220.67;*

- ii. *under the WWB Act, the long-term minimum-income allowance (langdurigheidstoelage) for a single person in 2004-2005 was € 318 per month;*
- iii *under section 35 of the WWB Act, crisis payments of up to € 107 may be made twice a month. According to the report, crisis payments to the households concerned averaged € 917 in total in 2002;*
- iv *the Committee asks the average amount of the rent subsidy.*

In 2007 housing benefits (rent subsidy) averaged €1,728 per year, or €144 per month. This is an average amount; people on a minimum income will have received significantly more.

A single person aged between 23 and 65 years claiming social assistance benefit is entitled to the following payments:

- Standard social assistance benefit is € 630.14 net per month, including holiday allowance as of 1 January 2008; the claimant may also qualify for an extra allowance of up to € 252.06 net per month (20% of the net minimum wage).
- If the person has been living at subsistence level for more than 5 years, and has no prospects of getting a job, they are entitled to an extra € 336 per year (2007 figures) (the long-term minimum-income allowance).
- If the person pays rent of no more than € 622, they are also entitled to housing benefit. How much they receive depends on the rent they pay. In 2007 the average benefit was € 144.
- The person will also be entitled to healthcare benefit to help cover the health insurance premium. Average healthcare benefit is € 46.
- If required, crisis payments are also available.

In total, this comes to € 1,100 net per month (excluding crisis payments).

e. *Right of appeal and legal aid*

The Committee asks whether the new WWB Act has made any changes to the right of appeal. It also asks whether free legal aid is available to enable applicants to exercise fully their right of appeal (Conclusions XVI-1, Ireland, pp. 356-358).

There have been no changes to the objection and review system since the WWB was introduced. The entitlement to legal aid is enshrined in the Constitution: anyone who requires legal representation but cannot pay for it is entitled to financial assistance, which we refer to as legal aid. Legal aid is regulated by the Legal Aid Council. In practice the Council pays a large proportion of the costs of the lawyer or mediator. The person concerned may be required to contribute to the costs, depending on their level of income. The municipality can make crisis payments available to cover this.

Paragraph 2

- f. *The Committee asks whether the situation has changed and whether persons with no established place of residence can now request social assistance from the municipality in which they are currently staying.*

The situation has not changed. A number of municipalities (known as *centrumgemeenten*) have been given the responsibility, and a budget, for providing assistance to the homeless (and other people without an established place of residence) in their region. If the homeless wish to apply for social assistance they need to register their details in the municipal personal

records database (*Gemeentelijke Basisadministratie* or GBA) of one of the *centrumgemeenten*. It is only possible to register with one municipality at any one time.

Paragraph 4

g. *The Committee does not know whether foreign nationals who do not come within the aforementioned categories but are nevertheless lawfully present in the Netherlands are entitled to social assistance. It asks the Government to clarify the situation in the next report.*

All persons lawfully resident in the Netherlands (as distinct from persons who are in the Netherlands lawfully but only for short-term purposes) are entitled to social assistance benefits. In general, it can be assumed that persons who are only permitted to stay in the Netherlands temporarily for short-term purposes (e.g. study, work placement, medical treatment and temporary work as an au pair) are still resident in their country of origin and therefore are not entitled to social assistance.

Anyone who enjoys the same status as Dutch citizens is also entitled to social assistance. This means all foreign nationals who are lawfully resident in the Netherlands, i.e. who:

- have right of residence as an EU/EEA or Swiss national;
- are in possession of a permanent or temporary residence permit;
- have right of residence on the basis of the Association Decision of the EEC/Turkey Association Council;
- are foreign nationals who have submitted an application on time for continued residence;
- are foreign nationals who have appealed on time against the withdrawal of residence rights.

EU/EEA nationals are not entitled to social assistance benefits during the first three months of residence (referred to as the free period).

h. *Finally, it invites the Government to reply to its question in the general introduction to these Conclusions on the social and medical assistance to which foreign nationals unlawfully in the country are entitled.*

Generally speaking, foreign nationals who have not been admitted but are habitually resident in the Netherlands (illegal aliens) and foreign nationals whose case is still being considered have no recourse to publicly funded allowances, benefits or services. Asylum seekers and persons in possession of a provisional residence permit (in connection with their residence status) cannot claim social assistance. They are however covered by a scheme under which they can claim benefit. Certain categories of foreign nationals who are not entitled to social assistance are entitled to benefits on the basis of the Services for Certain Categories of Aliens Regulations (*Regeling verstrekkingen bepaalde categorieën vreemdelingen*). These categories include victims of trafficking in women who are considering reporting this to the authorities and foreign nationals who are in the Netherlands for the purpose of family formation or reunification with an assistance benefit claimant and who do not yet know whether they can stay in the Netherlands.

With regard to the entitlement to medical care, please refer to the answer under paragraph 4 of article 13.

Paragraph 4

- i. The Committee asks whether unlawfully present foreign nationals, including persons whose applications for refugee or stateless person status have been rejected, are eligible for social and medical assistance in case of need, where necessary until they are repatriated.*

With regard to social assistance, please refer to the answer to question h.

Foreign nationals who are unlawfully resident will receive necessary medical care. Please refer to the answer under paragraph 4 of article 13.

Article 14 – The right to benefit from social welfare services

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

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

Article 14§1

- 1) *Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.*
- 2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.*
- 3) *Please provide pertinent figures, statistics or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).*

With regard to social welfare services provided under the Exceptional Medical Expenses Act reference is made to the previous reports, in particular the 18th report, p. 55 et seq.

New developments

One of the basic principles of the Exceptional Medical Expenses Act is that people should continue to live at home for as long as possible. They can receive care either in the home or at a healthcare institution.

The Social Support Act (WMO) entered into force on 1 January 2007. This Act is described under article 23, paragraph 1.

Before 1 January 2007, the benefits provided under the Exceptional Medical Expenses Act consisted of seven broadly defined services creating considerable freedom for arranging indicated care in consultation with a care provider. They were:

1. Domestic help: e.g. tidying up, cleaning, preparing meals.
2. Personal care: e.g. help with showering, bed baths, dressing, shaving, skin care, using the toilet, eating and drinking.
3. Nursing: e.g. dressing wounds, administering medication, giving injections, advising on how to cope with illness, showing clients how to self-inject.
4. Supportive guidance: helping the client organise his/her day and manage his/her life better, as well as day care or provision of daytime activities, or helping the client to look after his/her own household.
5. Activating guidance: e.g. talking to the client to help him/her modify his/her behaviour or learn new forms of behaviour in cases where behavioural or psychological problems exist.
6. Treatment: care in connection with an ailment, e.g. rehabilitation following a stroke.
7. Accommodation: some people are not capable of living independent lives, and require, for example, sheltered housing or continuous supervision in connection with forgetfulness. In some cases, a client's care requirements may be too great to address in the home environment, making admission to an institution necessary.

The Social Services Act will be implemented gradually. As a first step, domestic care has been shifted from the Exceptional Medical Expenses Act to the Social Services Act. Municipalities are now responsible for providing domestic care to those who need it. To that end they can conclude contracts with homecare institutions. In the coming years, more benefits will be transferred from the Exceptional Medical Expenses Act to the Social Services Act. The Exceptional Medical Expenses Act will remain available to people with a severe and prolonged need for care.

Article 14§2

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

Reference is made to the answers to the Committee's question below.

Questions of the European Committee of Social Rights regarding the previous (17th) Dutch report

paragraph 1:

- a. *The Committee asks whether fees are charged for the other social services (youth, alcohol and drug addicts and victims of domestic and sexual violence).*
- b. *The Committee asks whether there is an individual right to free counselling for people facing a social problem, as well as whether social services are adequately distributed on the territory.*

On 1 January 2008, mental health care was transferred from the Exceptional Medical Expenses Act to the Health Insurance Act. An insured person may be required to pay a contribution towards a psychotherapy session (€ 15.60 per session, up to a maximum of €702 for each calendar year; in the case of partner relationship therapy each partner pays half of these amounts) or a session of primary psychological care (€ 10 per session).

The government confirms that services provided under Dutch legislation are adequately distributed throughout the country.

- c. *The Committee also reiterates its question as to whether nationals of the other Contracting Parties to the Charter and of parties to the Revised Charter are granted equal treatment in access to social services with no length of residence requirement.*

The Exceptional Medical Expenses Act (AWBZ) imposes a qualifying period on persons who have recently taken up residence in the Netherlands and who already have an indication for admittance to residential care as referred to in the Act (e.g. nursing home care). The qualifying period is one month for each year a person was not insured under the AWBZ immediately preceding residence in the Netherlands, up to a maximum of 12 months. The qualifying period is reduced by one month for each year the person concerned was entitled to

medical care at the expense of the Netherlands, under an international social security coordination instrument. The qualifying period is applied to these persons, notwithstanding their nationality.

The Health Insurance Act imposes no qualifying period.

- d. *The Committee refers to its previous conclusion as regards the youth care services complaint procedure (Conclusions XV-2, p.363). It notes that a new procedure will be introduced outside the reference period by the new Youth Care Act, which replaces the 1994 Youth Services Act. It will consider it in the next supervision cycle and asks for detailed information on its implementation.*

Section 68 of the Youth Care Act provides for a right of complaint for young people in youth care services. This means that a young person may lodge a complaint against a care provider or youth care office. Complaints are handled by a complaints committee in accordance with the appropriate regulations. In addition, the institutions draft annual reports on the number and nature of complaints, the committee's decisions and the measures taken. The Youth Care Advice and Complaints Office has been set up to assist young people who wish to lodge a complaint (www.akj.nl). The office answers their questions, listens to their complaints and helps them lodge complaints with the appropriate organisations.

- e. *The Committee also asks which non-judicial and judicial remedies are open to users of each social service.*

With regard to the services provided under the Exceptional Medical Expenses Act, clients with complaints regarding their treatment by an Exceptional Medical Expenses Act implementing body must first lodge their complaint with the body in question. Under the General Administrative Law Act, an Exceptional Medical Expenses Act implementing body has an obligation to deal satisfactorily with such complaints. If the complainant is not satisfied with the response, he or she may submit a complaint to the National Ombudsman. The National Ombudsman assesses complaints on the basis of accepted standards of conduct. The Ombudsman considers whether the implementing body has acted in breach of the statutory code of conduct and whether its actions were reasonable, equitable, justified and duly careful.

An aggrieved client also has the option of submitting a complaint about an implementing body to the Healthcare Insurance Board. The board can then take action if appropriate, for example by issuing directives to implementing bodies. In the event of several complaints about the same subject, the board may inform the Minister about the problems. This may give grounds for policy changes or amendments to legislation.

An insured person has the right to lodge an objection with the body that implements the Exceptional Medical Expenses Act or with the CIZ (the organisation that assesses and issues medical indications) in response to a medical indication. The implementing body is legally bound to reconsider its decision and to make its findings on each lodged objection known. If the objection relates to a decision regarding entitlement to care under the Act or a related reimbursement, the implementing body is obliged, if it does not accept the objection in full, to ask the Healthcare Insurance Board for its advice before responding to the objection. This obligation does not apply to objections concerning cost sharing, which does not depend on medical factors. If the objector is dissatisfied with the implementing body's response to

his/her objection, he or she may lodge an appeal with an administrative court. The Court of Appeal is the Central Appeals Court for Public Service and Social Security Matters (*centrale raad van beroep*).

- f. *Finally, the Committee asks whether the legislation also provides for the protection of privacy rights, such as personal data, personal belongings of people resident in institutions, their contacts with the family, educational and leisure activities.*

In the Netherlands this subject is generally dealt with in separate legislation: the Personal Data Protection Act. The Exceptional Medical Expenses Act contains provisions concerning the exchange of data, including data about a person's state of health, but these provisions apply only to information exchanged for the purpose of implementing the Act. People who have access to personal data in the course of their work have an obligation to observe secrecy.

- g. *Quality of services*
The Committee has requested figures for the other categories of beneficiaries of social services.

No reliable data is available in the Netherlands for groups other than those mentioned by the Committee (the elderly and people with psychological, mental and/or physical disabilities).

- h. *The Committee asks that figures on expenses for youth services be provided alongside those for the other services for each period of reference.*

Expenditure on provincial youthcare services in the Netherlands (in millions of euros):

2004	2005	2006	2007
766	849	949	1055

The provincial authorities provide access to and deliver indexed youth care, and carry out law enforcement tasks (youth protection and probation). There are also municipal mental health services for young people and services for children with mild learning difficulties. Both are funded under the Healthcare Insurance Act and the Exceptional Medical Expenses Act.

- i. *According to the report, the Youth Care Inspectorate is responsible for overseeing youth care services. Supervision concerns both compliance with legislation and quality. Taking into account the broad involvement of private providers, the Committee reiterates its questions concerning how the provision of social services is monitored, which conditions, if any, social services providers must meet and what supervisory procedures are in place to ensure that these conditions are met in practice.*

The health insurers operate the Exceptional Medical Expenses Act scheme on their clients' behalf. The bodies that implement the provisions of the Act delegate various responsibilities – in particular the contracting of healthcare providers, the collection of patient contributions and the organisation of regional consultations – to regional healthcare offices. These offices receive a budget for their running costs. The Dutch Healthcare Authority sets the budget, which is subject to the approval of the Minister of Health, Welfare and Sport.

Each healthcare office carries out tasks for the implementing bodies in a particular region. It receives its data from the implementing bodies, and keeps records of the monthly accounts and advance payments for each institution.

With respect to certain healthcare entitlements, wherever possible an institution deals with only one implementing body for both financial settlement and medical supervision. To facilitate this system, the implementing bodies have handed over responsibility for administration and payments to a central administration office (CAK-BZ), which makes payments to the relevant institutions.

Before a person can qualify for care under the Exceptional Medical Expenses Act, it is necessary to establish whether care is really required and, if so, what type of care and how much care is needed. This 'indication' is issued by an organisation called the CIZ. The CIZ is an independent organisation responsible for determining care requirements impartially, objectively and thoroughly. The client chooses whether he/she wishes to receive the entitlement as care in kind or in the form of a personal budget; a combination of the two is also possible.

Dutch law provides for several supervisory instruments. The Healthcare Insurance Board is responsible for overseeing the lawful and effective implementation of the Exceptional Medical Expenses Act and the Health Insurance Act by care insurers and care facilitators, and has the authority to set policy rules for implementing the Act's provisions.

The Healthcare Inspectorate is responsible for overseeing the quality of public health and the existence of regulations and their observance by care providers. The Inspectorate checks the quality of the care delivered by medical professionals by, for example, monitoring their competence to perform medical procedures. Another important task is ensuring that care providers meet the quality criteria for effectively and efficiently delivering responsible care of a good standard that meets the patient's needs.

The Dutch Healthcare Authority regulates tariffs, budgets and services. It also oversees the lawful and effective implementation of the provisions of the Exceptional Medical Expenses Act by care insurers, care offices and the central office that administers the Act.

The bodies that implement the Exceptional Medical Expenses Act have a duty of care in that they are required to ensure that their clients can obtain the health care to which they are entitled. To this end, the bodies or the healthcare offices they engage enter into contracts with healthcare providers and approved institutions. These contracts regulate the volume of healthcare services provided, the quality, charges and other such matters.

paragraph 2

- j. The Committee asks that the next report confirm that effective and equal access to social services provided by non-state organisations is guaranteed in accordance with the criteria mentioned under the interpretation of Article 14§1.*

The government confirms that equal access to the services provided under the Exceptional Medical Expenses Act is guaranteed to all insured persons. These services are provided mostly by non-state organisations, so this guarantee applies to these organisations. The social services provided under Dutch law are in conformity with the interpretation of paragraph 1. However, where the legislation requires insured persons to share in the cost, this requirement applies to all insured persons, notwithstanding their social and financial situation.

In the event that the insured person is unable to pay his/her contribution, the care provider is permitted by law to waive payment of the contribution.

- k. *The Committee asks what body is responsible for supervising non-state providers and how supervision is carried out.*

Since the services provided for under the Exceptional Medical Expenses Act are delivered mostly by non-state organisations, reference is made to part i. above.

- l. *The Committee requests information on the procedure that NGOs or other non-state providers must undergo, and the conditions they have to fulfil, to become service providers and their proportion vis-à-vis public services.*

Since the services provided for under the Exceptional Medical Expenses Act are delivered mostly by non-state organisations, reference is made to the last paragraph of part i. above.

Article 23 – The right of elderly persons to social protection

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

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

- 1) *Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.*
- 2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.*
- 3) *Please provide pertinent figures, statistics or any other relevant information on measures taken to ensure that elderly persons have access to adequate benefits in cash or in kind; on the level of public expenditure for social protection and services for the elderly; on the accessibility of measures and the number of elderly people benefiting from them; on the number of places available in institutions for elderly persons; on the number of elderly living in such institutions, and on whether a shortage of places is reported.*

Full membership of society

- a. The General Old Age Pensions Act (*Algemene Ouderdomswet*, AOW) provides a basic pension for people aged 65 and over, entitlement to which accrues from the age of 15. People with a partner under the age of 65 with only low earnings, or no earnings at all, are eligible for a supplementary pension.

Section 4, subsection 1 of the Social Support Act (*Wet maatschappelijke ondersteuning*), introduced on 1 January 2007, states that ‘to compensate for the limitations experienced by a person as referred to in section 1, subsection 1 (g) (4°), (5°) and (6°) in his ability to live independently and to take part in society, the Municipal Executive must take measures in the sphere of social support that enable him **a.** to run a household; **b.** to be mobile in and around the dwelling; **c.** to provide access to transport for local mobility; **d.** to meet other people and, in so doing, form social ties.’

For further information on these pieces of legislation, please see the response under article 14, paragraph 1.

- b. In accordance with section 1, subsection 1 (g) of the Social Support Act, social support

includes providing information, advice and client support. An English translation of this legislation can be found at:

<http://www.minvws.nl/en/themes/social-support-act/default.asp>.

For the implementation of the Social Support Act, it is best for local authorities to have one or more central locations where people can go with requests for support under the Act: a local service desk, in other words. Central government has developed three instruments to help local authorities set up a local service desk:

<http://www.invoeringwmo.nl/WMO/nl-NL/Kernthemas/lokaaloket.htm>

Free choice of life-style

- a. The Subsidised Rented Sector (Management) Decree (*Besluit beheer sociale-huursector*, BBSH) provides the legal basis for the operations of housing associations. It defines the areas in which they may operate and the requirements for acquiring housing association (approved institution) status. The Decree also regulates matters such as supervision by the Minister and the obligation to draw up annual accounts, an annual report and a public housing report.

Chapter III, part 2b of the Decree obliges approved institutions to help provide suitable housing for the elderly, disabled and people requiring care or support (<http://www.wetten.nl/Besluit%20beheer%20sociale%2Dhuursector>).

Section 4, subsection 1 of the Social Support Act, introduced on 1 January 2007, states that ‘to compensate for the limitations experienced by a person as referred to in section 1, subsection 1 (g) (4°), (5°) and (6°) in his ability to live independently and to take part in society, the Municipal Executive must take measures in the sphere of social support that enable him **a.** to run a household; **b.** to be mobile in and around the dwelling; **c** provide access to transport for local mobility; **d.** to meet other people and, in so doing, form social ties.’

- b. The organisation of curative care distinguishes between GP care, provision of medicines, general oral hygiene services, midwifery and maternity care, paramedic care, ambulance care and transport, specialist medical and hospital care, rehabilitation, transfusions and transplants. Curative care aims to treat and cure acute and chronic somatic disorders, and involves many institutions and professionals. The sector has traditionally been divided into inpatient and outpatient care. Outpatient care is provided outside a hospital or institutional setting, while inpatient care is provided in hospitals and institutions. This distinction has become less important in recent years due to the modernisation of curative care and the development of demand-driven care. Outpatient care is provided largely by professionals such as GPs, dentists, oral hygienists and orthodontists, midwives, maternity nurses, paramedics and support staff. Inpatient care is provided by medical specialists and nursing staff working in hospitals and rehabilitation centres. A wide range of specialist and nursing care is provided in a polyclinic or clinic setting. Ambulance services are also regarded as curative care.

The basic health insurance package ensures that all residents of the Netherlands have insurance cover for medically necessary care. Everyone is obliged to take out basic health insurance. The cover provided by the basic package has been defined in law and is the same for everyone. It includes all necessary care such as hospital care, medication and GP care. Premiums differ from one insurance company to another. People are also free to take out extra cover for care not covered by the basic package, including physiotherapy,

alternative medicine and extra dental care. The cover, costs and conditions applying to these supplementary packages differ from one insurance company to another. Each company provides a range of different packages.

The Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ) provides for social insurance covering medical expenses. Everyone who lives or works in the Netherlands is covered, and has a right to reimbursement of the costs of care covered by the legislation. The Act covers major medical risks that are not covered by any health insurance policies, medical expenses that virtually no one can afford to pay themselves, including long-term hospitalisation or long-term care in a nursing home or institution for the disabled.

Living conditions in the institutions

The Care Institutions (Quality) Act (*Kwaliteitswet zorginstellingen*) entered into force on 1 April 1996. It sets general standards for care institutions. Every care institution (or umbrella organisation) is required to flesh out the general standards set out in the legislation, which applies to all institutions (hospitals, nursing homes, outpatient mental healthcare institutions, private clinics etc.) in the care sector.

All institutions must provide or have:

1. responsible care
2. quality-oriented policy
3. quality assurance systems
4. annual reports.

The Health Care Inspectorate (IGZ) monitors compliance with the Care Institutions (Quality) Act.

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

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

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

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

In Chapter 2 of the National strategic report on Social Protection and Inclusion (Action plan on Combating Poverty and Promoting participation) (annex 10) is described. Here you will find references to the legal framework on the right to protection against poverty and social exclusion and the nature of, reasons for and extent of any reforms since 2006. Chapters 3 and 4 describe the pension respectively the healthcare system in the Netherlands and Chapter 1 gives an general overview.

⇒ Annex 10: National strategic report on Social Protection and Inclusion

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

Figures, statistics and any other relevant information are to be found in the appendices of the National strategic report on Social Protection and Inclusion (annex 10), especially Appendix II. Information on the methodology followed or criteria used to measure poverty and social exclusion are to be found in paragraph 2.1.2, 2.2 and 2.6.6.

LIST OF ANNEXES

1. Arbobalans 2006 (separate)
2. Monitor Arbeidsongevallen in Nederland 2005 (separate)
3. Signaleringsrapport Beroepsziekten '07 (separate)
4. Health Insurance in the Netherlands, the new health insurance system from 2006 (separate)
5. Summary of final report on the National Environment and Health Action Plan
6. European Code report for the period from 1 July 2007 to 30 June 2008
7. European Code report for the period from 1 July 2005 to 30 June 2006
8. European Code report for the period from 1 July 2006 to 30 June 2007
9. Direct Request, Part III “Concerning Old Age Benefits”, the Annexe to the European Code report for the period 1 July 2007 to 30 June 2008
10. National Strategic report on Social Protection and Inclusion (separate)