Feasibility Study for a Child Guarantee

Country report – the Netherlands

2019

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*Contact:* Julius op de Beke

*E-mail:* Julius.Opdebeke@ec.europa.eu

*European Commission
B-1049 Brussels*

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In 2015, the European Parliament called on the European Commission and the European Union Member States, “in view of the weakening of public services, to introduce a Child Guarantee so that every child in poverty can have access to free health care, free education, free childcare, decent housing and adequate nutrition, as part of a European integrated plan to combat child poverty”. Following the subsequent request by the Parliament to the Commission to implement a Preparatory Action to explore the potential scope of a Child Guarantee for vulnerable children, the Commission ordered a study to analyse the feasibility of such a scheme.

The feasibility study for a Child Guarantee is carried out by a consortium consisting of Applica and the Luxembourg Institute of Socio-Economic Research (LISER), in close collaboration with Eurochild and Save the Children, and with the support of nine thematic experts, 28 national experts and an independent study editor.

For more information on the feasibility study for a Child Guarantee, see: <https://ec.europa.eu/social/main.jsp?catId=1428&langId=en>

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# Summary

**In general.** The Netherlands has an extensive and complex system of measures that protect the interests of citizens and therefore also those of children, including the four target groups (TGs) of this study. This system is the result of international treaties to which the Netherlands is a party, the constitution and further legislation. Dutch policy is mainly generic and does not focus on specific target groups. The four TGs discussed in this study are therefore not addressed as such in Dutch policy. Consequently, EU funds are not used specifically for these TGs.

Although the policy is extensive in nature, there are gaps here and there. The analysis of the access of the different TGs to each PA shows that in the Netherlands these TGs are more numerous than the overall group of children to face problems of housing (comfort and costs), as well as unmet medical needs and educational and child care costs (see Feasibility Study for a Child Guarantee [FSCG] Inception Report, 2018). Other examples are the lack of a policy that protects vulnerable households from water supply cut offs or home evictions. Furthermore, it appears that there are considerable discrepancies between the policy intentions and day-to-day implementation practice. Noteworthy in this context are the waiting lists for youth care, for social rental housing or the regional variation in suitable education. These problems are not specific to the TGs; they are disproportionately affected by them because they are overrepresented in the poor households.

On the positive side, an increasing amount of attention is paid to reducing child poverty in the Netherlands; the aim is to tackle the problem coherently and integrally. It is obvious to include in this policy context the improvement actions proposed in this report.

**Education.** Children in the Netherlands have the right to free education and freedom of school choice. They are by law required to receive schooling. The school system aims to offer appropriate schooling to every child within their local area. There are concerns, such as segregation in primary schools by parental educational background and income. There is also a large group of children temporarily not receiving formal schooling. The educational provision for children of refugees has inefficient features and the support offer for children with complex special needs is insufficient. Another concern are regional discrepancies in the organisation of education for children with special needs.

**ECEC.** Children residing in the Netherlands can access early childhood education care facilities. The ECEC-sector is understaffed, which results in waiting lists for day care nurseries in some regions. Furthermore, there are indications that the organisation of the tax benefits-system leads to a decrease in the number of TG children attending ECEC-facilities.[[1]](#footnote-2) Children with working parents in the lowest income groups appear to attend ECEC-facilities less often than their counterparts from higher income groups. Only 35% of the municipalities with an asylum location have ECEC available for refugee children.

**Housing.** There are several policies and programmes in place that aim to ensure that housing is affordable. However, the Dutch housing market is increasingly tightening, resulting in increasing prices and long waiting lists for social housing. The most urgent issue with regard to decent housing is availability. The shortage of available affordable housing sometimes leads to unwanted outcomes such as home evictions, or energy or water cut-offs, in which children are the victim of their parents’ vulnerable situation.

**Health.** The Dutch health care system provides children free access to health care services by subsidising the basic health insurance coverage. However, rising health care costs are a concern and may affect low-income households disproportionately. Moreover, the current child health care system has led to discrepancies in accessing health care and receiving quality of care, depending on where the child resides. Vulnerable population groups, including low SES-households and non-western migrants, show poorer health outcomes than their counterparts. The Dutch health care system partly addresses this gap by means of health care measures for children of recent migrants and refugees, but no other specific national health programmes are in place for the remaining FSCG target groups.

**Nutrition.** Overall, children residing in the Netherlands can access adequate nutrition and receive tailored information and support to empower them in doing so. Through schools, children are often exposed to information and a healthy food environment to encourage them to make healthy food choices. However, there are only a handful of nutrition programmes that target children from vulnerable population groups, whilst the Dutch government recognises the need for combating unhealthy food consumption among them.

**Children in institutions.** Regulations and policies are designed to prevent out-of-home placement of children by means of (specialist) support in the home situation. If out-of-home placement cannot be prevented, the policy is that family-oriented care is preferable to residential care. However, practice is unruly. Serious problems are often identified too late and there is insufficient availability of specialist assistance in the home situation.

# Overall situation

## Overall situation of child poverty or social exclusion[[2]](#footnote-3)

The Dutch situation can be described as follows. Figure 1 shows the development in the number of persons ‘at-risk-of-poverty-or-social-exclusion’ (AROPE) in the period 2008 to 2015. This figure appears to have increased from 2.4 million in 2008 to 2.7 million people in 2015 (rounded off) (15.7% and 16.4% of the population respectively). During this period, there was no monotonously increasing trend; probably there was a relationship with the double dip that characterised the crisis. As of 2014, the AROPE indicator decreased and the number of people at risk of poverty or social exclusion dropped slightly. This development was caused by the decrease of the Severely Materially Deprived indicator (SMD indicator); the two other indicators did not decrease, even though their growth rate diminished.

**Figure 1: Europe 2020 indicator ‘At-risk-of-poverty-or-social-exclusion’ (Netherlands, whole population)**

Source: EU-SILC, published earlier in: Kruis and Van Waveren, 2017

Figure 2 shows the development of the AROPE indicator specifically for children (0-17 year). This development is broadly consistent with that for the entire population: an increase over the entire period and an identifiable double dip. The difference is that the decrease in the AROPE indicator had set in earlier, since 2011. In addition, the decrease concerned was again slight. The underlying component indicators do not show the same trend.

**Figure 2: Europe 2020 indicator ‘At-risk-of-poverty-or-social-exclusion’ (Netherlands, Children 0-17)**

Source: EU-SILC, published earlier in: Kruis and Van Waveren, 2017

In the Netherlands, several studies have been published in recent years on the nature and extent of child poverty. A good overview can be found in a recent publication of the Social and Economic Council of the Netherlands (Sociaal-Economische Raad [SER], 2017). Although these studies use definitions that differ from those of Eurostat, the observed trend is comparable to the Eurostat figures (SER 2017, p.16): from 2008, the risk of poverty or social exclusion increased for children; as of 2013 a slight decrease was visible. In 2017 this decrease continued, but at a rather marginal level (Centraal Bureau voor Statistiek [CBS], 2017a).

In brief, the available sources indicate a small decrease in child poverty, but this decrease is very modest and is not (yet) supported by all component indicators.

More figures and tables are published as annexes in Frazer and Marlier (2017). We find that on all indicators and for all subgroups, the Netherlands scores better than the EU average, in most cases even significantly better.

## Overall situation of children living in precarious family situations

*Size of each of the 4 subgroups in EU countries[[3]](#footnote-4)*

*Size of subgroup ‘Low-income/socio-economic status children’*

Based on EU-SILC data, figure 3 contains combined information on the EU-indicators ‘Child specific deprivation’ and ‘At-risk-of-income-poverty’. The figure shows that the Netherlands is positioned in group 4. This group contains EU countries that suffer from a low-to-medium level of child deprivation rate and income poverty.

**Figure 3: Proportion of children (aged between 1 and 15 years) who lack at least three items (out of 17) and proportion of children who suffer from income poverty, EU-28 Member States, 2014, %**



Source: EU-SILC 2014, computations Guio et al. (2018), as published in FSCG Inception Report (2018)

*Size of subgroup ‘Children living in single-adult households’*

Figure 4 presents the proportion of children living in single-adult households in EU countries. In the Netherlands the proportion of children living in single-adult households is 10.9%, a rather average position in comparison to the other EU-countries (range from 4% to 18%). It also shows that the proportion of children in single-adult households confronted with income poverty and/or child-specific deprivation is very high in most countries (range between 16% and 94%). In the Netherlands the share is substantial, but relatively mild (44.7%) in comparison to the other EU-countries. Only three have better scores.

**Figure 4: Proportion of children (aged between 1 and 15 years) living in single-adult household (left hand scale) and, among them, proportion of children who lack at least three child-specific items (out of 17) or who suffer from income poverty (right hand scale), EU-28 Member States, 2014, %**

Source: EU-SILC 2014, UDB version November 2016, own calculations, as published in FSCG Inception Report(2018)

*Size of subgroup Roma children*

No reliable figures are known about the size of the Roma in the Netherlands. Estimates range from a few thousand (various newspaper reports) to a maximum of 35,000 (Sollie et al., 2013).

The housing and living conditions of Roma are monitored under commission of the Ministry of Social Affairs and Employment (Risbo, 2018). The monitor study shows a range of problems that also concern the children: early school leaving and absenteeism, involvement in criminal activities, and forced marriages. The monitor shows that the problems have not diminished in the period between 2013-2018. The minister of Social Affairs and Employment will start a pilot with mediators, aimed at promoting the participation of young Roma adolescents in (further) training, internships and job placements (Koolmees, 2018).

In 2018, Defence for Children conducted research into solutions for Roma children who are victims of criminal exploitation. In the Netherlands, since 2007, the problem has been identified of unaccompanied Eastern European children on the move who are involved in criminal activities or begging. They are suspected victims of criminal exploitation and trafficking. In 2016, a total of 252 Eastern European children were arrested for offences such as shoplifting, pickpocketing, home invasion tricks and burglary.

Within the Tackling Exploitation of (Roma) Children Programme, carried out by the Dutch government between 2011 and 2016, municipal testing grounds were set up. In these testing grounds new methods, methodologies and insights have been developed about working with multi-problem families with a Roma background. These methodologies and knowledge documents are available to other municipalities and chain partners (CCV).

## Overall situation of children residing in institutions

An indication of the number of children residing in institutions can be provided with data from the Eurochild National Surveys of 2010 (2007-8 data). In the Netherlands out of 14,516 beds for children in residential care, 4,500 are targeted at children with disabilities. Given the complexities in the data a comparison with other EU-countries is hard to make.

**Table 1a: Number of children in residential care by EU country**

|  |  |
| --- | --- |
| Netherlands (No of beds) | Eurochild National Surveys 2010 (2007-8 data) |
| Number of children in residential care (at the end of the year) | 14,516 |
| Number of children with disabilities out of the total number of children in residential care | 4,500 |

Sources: [Unicef-irc.org](https://www.unicef-irc.org/databases/transmonee/); [Openingdoors.eu](http://www.openingdoors.eu/category/resources/) and [Eurochild.org](https://www.eurochild.org/fileadmin/public/05_Library/Thematic_priorities/06_Children_in_Alternative_Care/Eurochild/Eurochild_Publication_-_Children_in_Alternative_Care_-_2nd_Edition_January2010.pdf), as published in FSCG Inception Report (2018)

More recent data about children in residential care are presented in the CBS Youth Monitor (Jaarrapport Landelijke Jeugdmonitor 2018).

Table 1b: Number of children under youth care by type of care (x1,000)

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2015 | 2016 | 2017\* |
| Fostercare | 21,9 | 21,4 | 21,2 |
| Family-oriented care (e.g. group home) | 5,3 | 5,1 | 4,5 |
| Secure residential youth care | 2,7 | 2,5 | 2,5 |
| Other | 21,9 | 19,9 | 16,7 |

Children with multiple forms of youth care appear several times in the table.

\* provisional

## Overall situation of children of recent migrants and refugees

Figure 5 shows the share of children aged below 18 with at least one parent born outside the EU. The share varies considerably across Member States. The Netherlands scores relatively high (EU-SILC: 16%; LFS: 19,6%).

**Figure 5: Share of children aged below 18 with at least one parent born outside the EU, 2017, %**

Note: In the LFS, the focus is on ‘dependent children’, i.e. children below the age of 15 plus children aged 16-24 who are inactive and live with at least one of their parents.

Source: EU-SILC (2017) and LFS (2017), as published in FSCG Inception Report (2018). No data in EU-SILC (2017) for UK and IE

## Overall situation of children with disabilities

Figure 6 shows the proportion of children suffering from limitations in their daily activities in the various EU countries. In the Netherlands a (more or less) average share of children suffers from severe limitations in daily activities (1%); a relatively large share is limited but not severely in daily activities (5%).

**Figure 6: Share of children severely limited or limited (but not severely) in daily activities during the past 6 months, Children 0-15 years old, EU countries, 2017, %**

Source: EU-SILC 2017, ad-hoc module, Users’ Data-Base (UDB) version November 2018, own calculations, as published in FSCG Inception Report (2018)

There is no national administrative definition of children with special needs. In a study from 2016, researchers tried to estimate the number of children with special needs based on the number of children for whom special care was requested (Tierolf, Gilsing, Steketee, 2016). It concludes that, in 2015, at least 2.7% of all Dutch children have a handicap, which is expected to be a huge underestimation because not all children with a handicap are registered. Moreover, this study excludes children with chronic psychiatric problems, because there is no reliable data available. From these 93,500 children, two-third had a mental disability; thirty percent had a physical disability; and fifteen percent had a sensory disability. Figure 7 presents the distribution of children according to the subjective assessment of their health status by the household respondent. Although the proportion of children with very good health varies considerably between countries, there is much less variation in the proportions of children with (perceived) fair, bad or very bad health. In the Netherlands, the health of 4% of children is perceived as fair, bad or very bad, which is average. The score for ‘very high’ is relatively low in the Netherlands.

**Figure 7: Repartition of children according to the perceived general/overall health, Children 0-15 years old, EU countries, 2017, %**

Source: EU-SILC 2017, ad-hoc module. UDB version November 2018, own calculations. No data available for IE and UK, as published in FSCG Inception Report (2018)

# Description and assessment of main policies and programmes in place and recommendations for improvements

## The Netherlands: International and national context

As stated in the Dutch Constitution, the Dutch government is committed to promoting the development of the international legal order. This commitment is reflected in the various international human rights agreements that the Netherlands has been a party to for over the past decades, including agreements for promoting and securing the rights of children:

* the International Covenant on Civil and Political Rights;
* the International Covenant on Economic, Social and Cultural Rights;
* the International Convention on the Elimination of All Forms of Racial Discrimination;
* the Convention on the Elimination of All Forms of Discrimination against Women;
* the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;
* the Convention on the Rights of the Child;
* the International Convention for the Protection of All Persons from Enforced Disappearance;
* the Convention for the Protection of Human Rights and Fundamental Freedoms;
* the European Social Charter.

Committing to these agreements entails that the Dutch government has to meet legally binding obligations, such as ensuring that all children in the Netherlands have access to education, housing and health care services, and that assistance in accessing these services is provided when needed. For example, being a party to the Convention on the Rights of the Child means that the Netherlands is required to combat disease and malnutrition among children “through the provision of adequate nutritious foods and clean drinking-water” (OHCHR, 1989). Moreover, the Convention on the Rights of Persons with Disabilities states that Member States shall take measures to prevent discriminatory denial of access to health care, health services or food and fluids on the basis of disability (UN, 2006).

These agreements require Member States to periodically submit progress reports to international committees for monitoring and evaluation purposes. Countries will then receive input and recommendations to refine their policies and practices in specific areas. The committees generally comprise experts in the field, such as the UN Committee on the Rights of Persons With Disabilities and the Committee on the Rights of the Child. Both committees comprise 18 independent international experts who are elected for a term of four years by States parties (OHCHR, n.d.).

Enforceable rights. The UNCRC report (2014) on the Netherlands shows that a number of improvements have been made in the period under review. They concern the promotion of children’s rights (a Children’s Ombudsman took office in 2011, the Netherlands Institute for Human Rights was launched in 2012); participation by children and young people; preventing the need for care; services for children; and protection of children. Furthermore, it is relevant to emphasise that the Netherlands has made reservations regarding Articles 26, 37 and 40 of the Convention on the Rights of the Child.[[4]](#footnote-5)

At the national level, the Dutch social welfare system has recently undergone a major transformation in its policies and practices for fostering an inclusive society for all children and youth. Since 2015, key responsibilities and tasks in youth care, long-term care and employment support have been shifted from national level to municipalities at local level.With this ‘decentralisation’, national policies provide municipalities with a framework and guidelines to further design and implement local policies for ensuring an inclusive local environment. For instance, municipalities are now held responsible for providing young children and youth with access to health care services, family support and housing.

Within this context, policies and programmes focused on health, education, housing, nutrition and early childhood education and care follow primarily overarching national guidelines and frameworks, but are mostly coordinated, refined and implemented at local level.

## Description and assessment of main policies in place and recommendations for improvements to ensure adequate nutrition

**Current national policies for a wide audience**

In the Netherlands, there are currently several national policies to promote access to adequate nutrition and a healthy food intake. Overall, the current national policies focus on a wide generic audience without specifically targeting any of the target groups as specified for the FSCG.

Most recently, the Dutch Ministry of Health, Welfare and Sport (VWS) announced a new National Prevention Agreement for the period 2018 to 2040. The agreement reflects commitment to the implementation of new health policies by a broad range of stakeholders from various sectors, including local councils, trade and industry, health insurance, health providers, and the sports sector. Combating overweight and promoting healthy nutrition is a key focus area in this agreement.[[5]](#footnote-6) With the agreement, the Dutch government is committed to reach specific health targets for children and youth, such as decreasing the prevalence of overweight and obesity.[[6]](#footnote-7) Moreover, specific key activities have been identified to promote adequate nutrition among children, including:

* implementing stricter policies in the whole food industry for marketing and branding children’s food;
* reaching agreements with different food industries to lower the calorie intake of specific food products that generally comprise a high sugar level (e.g. soft drinks, biscuits and sweets);
* investing in creating healthier sports club canteens and school canteens;
* developing a dedicated school intervention programme for children with special education needs to promote a healthier lifestyle;
* training professional child care workers in promoting and creating healthy child care centres;
* implementing new health practices for health workers (e.g. general practitioners and midwives) to more actively advise pregnant women to cease any alcohol consumption and smoking behaviour during pregnancy;
* undertake research in preventing excessive food consumption among specific population groups and how to better reach these population groups for more effective interventions.

The Ministry of Health, Welfare and Sport will oversee and lead the implementation of the agreement. Monitoring and tracking activities will be annually conducted by the National Institute for Public Health and the Environment (RIVM, 2018).

Another important policy development is the launch of the National Food Agenda (*Voedselagenda*) in 2015 in response to an increasing demand on the food industry by a growing population, coupled with increasing patterns of unhealthy food intake and diet-related non-communicable diseases. With the Food Agenda, the Dutch government is committed to become a leading country in healthy and sustainable food policies and practices (Ministry of Agriculture, Nature and Food Quality, 2016). The Food Agenda comprises several focus areas, including implementing nutrition policies and practices for maintaining a healthier lifestyle. As part of this focus area, a national policy programme was launched in 2017 called Learning to eat at a young age (*Jong Leren Eten*), a joint effort by the Dutch Ministry of Economic Affairs and the Ministry of Health, Welfare and Sport (VWS). The programme acknowledges the variety in nutrition programmes for children in the Netherlands and aims to bring together all these programmes for a more focused, integral, and effective national approach. Ultimately, the programme aims to adopt food education as an embedded and structural element in all school policies. The programme is expected to end by 2020.

Another key policy is a monitoring policy that has been embedded in the Dutch health care system for decades. The child health care system offers subsidised periodic health checks to pregnant women, young infants and toddlers (from the age of 0 to nearly four years old) to monitor their overall health, including their food and vitamins intake (GGD HN, n.d.). Consultations are free of charge. However, the consultations are attended on a voluntarily basis by parents and their children.

In addition to health monitoring, the National Institute of Public Health and Environment (RIVM) carries out various public health monitors, such as longitudinal nutrition monitors for tracking the food intake and associated health outcomes among children and youth, including children from vulnerable population groups (RIVM, 2018). These monitors also provide an understanding of current inadequate nutrition patterns, which over the past decade increasingly emphasised a growing trend in the prevalence of overweight, obesity and diet-related non-communicable diseases in the Netherlands (van Dam & Schippers, 2016 and Boer et al., 2016).

**Current national programmes for a wide audience**

In light of the above policies, the Dutch government has also implemented several national programmes to enhance and improve practices in relation to healthy nutrition. In line with the national policies, nearly all national programmes focus on a wide audience, without targeting the target groups as specified for the FSCG.

When looking at specific programmes that support vulnerable population groups in affording and accessing food, three main measures can be observed. Firstly, the Participation Act serves as the – means-tested – Dutch safety net. It provides a minimum income to anyone legally residing in the Netherlands who has insufficient means to cover the basic costs of living. Secondly, the government provides monetary support to households through child benefit support. The aim of this benefit is to support parents in covering the expenses of raising a child up to the age of 18 years (SVB, n.d.). Parents caring for a child with disability can apply for extra financial support. Thirdly, low income households can access in-kind support through food banks by receiving free food packages on a weekly basis. Food banks are private organisations; they have a strong presence in the Netherlands by being located in 96% of all municipalities (Vereniging van Nederlandse Voedselbanken, 2018). The National Association of Food Banks aims to follow in its food policies the national nutritional guidelines as recommended by the Netherlands Nutrition Centre (*Stichting Voedingscentrum Nederland*). However, an interviewed stakeholder noted that food banks in general do not consider special dietary requests in their food packages, meaning that the needs of children with food allergies or food intolerances are not being met.

Other programmes aimed at accessing adequate nutrition for children primarily involve education programmes to promote better and more adequate food choices. More specifically, the identified main programmes aim to:

* inform and educate children on healthy nutrition and lifestyle choices, rather than providing in-kind support (e.g. providing food);
* target children in a school environment;
* follow an integral approach through interventions specifically focused at the child as well as the child’s social and physical environment (e.g. parents and school canteens);
* place the emphasis on combating overweight and obesity through healthier food choices;
* indirectly also combat micronutrient-related malnutrition through the promotion of healthier food choices.

**Programmes for specific target groups**

At the time of writing, most national programmes or initiatives do not specifically target the target groups as specified for the FSCG. Only one national programme, the Healthy School programme, prioritises in its funding approach schools located in areas with high numbers of low-SES households and secondary schools for children with special education needs. However, at local level, a handful of nutrition programmes (endorsed by the Ministry of Health, Welfare and Sport) specifically target children from low-SES households and children from a non-EU migrant background, with the latter group mostly comprising children of Turkish or Moroccan descent (RIVM, n.d.). These programmes are primarily focused on combating overweight or obesity and are mainly offered through local schools and local community health centres.

**Assessment and conclusions**

Based on the above findings, we can observe that overall, the Dutch government has several policies and programmes in place to ensure adequate nutrition is available and accessible to all children. However, some caveats are noteworthy:

* The current national programmes show a limited number of specific policies to target the target groups as specified for the FSCG. Only a handful of local programmes have been identified that target children from low-SES households and children from non-EU backgrounds. Importantly, the Dutch government recognises the need for programmes that target specific population groups to combat excessive and unhealthy food consumption(VWS, 2018). In this light, one of the government’s goals as specified in the National Prevention Agreement (*Nationaal Preventieakkoord*) is to undertake further research in how to better reach and target specific population groups. However, no further specification is provided on the key features of these population groups, other than that these population groups are generally hard to reach.
* Given the freedom that people exercise in food intake, current policies and programmes are mainly focused on informing and educating children on healthy food choices to ultimately drive positive behaviour change.
* School canteens are not embedded in the Dutch school system as in other countries (e.g. England). In the Netherlands, primary school students are required to bring their own lunch to school. Secondary and vocational schools do have school canteens but students are expected to pay for all food products. Given this context, current school nutrition programmes mainly focus on food education rather than on the actual provision of nutritious food.

In this light, the current Dutch main policies and programmes focused on nutrition lead to a ***moderate security*** of ensuring that the four target groups (TGs) as specified for the FSCG have access to adequate nutrition. More specifically:

* The **availability** of nutritious food is for all four TGs partly secured through:
1. new healthier nutrition standards that the government is implementing (and will implement) in the food industry by following national nutrition guidelines;
2. policy guidelines that food banks are committed to in accordance with national nutrition guidelines. However, no formal monitoring policies are in place to evaluate the extent to which food banks are implementing the national nutrition guidelines.
* The **accessibility** of nutritious food is for all four TG partly ensured by:
1. legal national and international standards that the Dutch government is expected to follow in order to prevent non-discriminatory practices in the Dutch society. However, it should be noted that access to clean drinking-water is not fully guaranteed to Dutch households as they can be cut off from utility services when failing to pay their utility bills, including water from their water supplier. For example, an interviewed expert referred to over 15,000 residential water shut-offs that occurred over a three-year period in The Hague;
2. informing children and their parents of healthy food choices and the national nutritional guidelines through schools and the health care sector.
* The **affordability** of nutritious food for all four TG is partly ensured by monetary support (Participation Act), child benefit support and in-kind support through food banks.
* Current programmes focused on the promotion of nutritious food are **adaptable** to the local living environment of all four TGs (mainly at schools and sport clubs). However, participation in these programmes is voluntary for schools and sport clubs, meaning that not all children (all four TGs as well as their counterparts) will be exposed to adequate nutritious environments.
* **Acceptability** can only be seen to a limited extent in current programmes and policies that promote adequate nutrition. Only one national programme specifically prioritises children from low-SES households and secondary schools for children with special education needs. Moreover, only a handful of local projects are available to children from non-EU backgrounds.

## Description and assessment of main policies in place and recommendations for improvements to ensure access to free education

**Current national policies for a wide audience[[7]](#footnote-8)**

Freedom of education is an important feature of the Dutch education system and it is guaranteed under Article 23 of the constitution. It includes the right to establish schools and to provide teaching based on religious, ideological or educational believes. As a result, the Dutch education system comprises publicly-run and privately-run schools. Public schools are neutral in terms of religion or ideology and provide education on behalf of the state. Private schools are either based on philosophical or religious beliefs. They are state-funded although not founded by the state. The freedom of education means that schools are free to determine what is taught and how. This freedom is, however, strongly limited by a strict set of standards set by the Ministry of Education, Culture and Science in educational legislation. These standards apply to both public and private education.[[8]](#footnote-9)

This system offers students and their parents freedom to choose a school in line with their own views, ideologies and needs. Public schools are open to all students regardless of their outlook on life. Private schools may refuse students whose parents’ religion or faith differ from the school’s religion or faith. This is, however, uncommon, except for the more orthodox religious schools.

Free primary and secondary education is available to everyone. Parents are only asked to pay a voluntary contribution for special activities and events outside of the curriculum. The amount of the contribution varies among schools. In practice, some unclarities may occur, for instance when parents are asked to contribute to the funding of school computers or school trips. Parents can sometimes apply for financial support, mostly offered by local municipalities. However, the Inception Report (2018, p.81) shows that households in precarious family situations more often than other families find it difficult to cover the costs of formal education.

The Compulsory Education Act (*Leerplichtwet*, 1969) sets down the obligation for all children aged 5-16 to attend school full-time. However, nearly all attend school from the age of four. Since August 2007, there is the obligation to continue education in order to obtain a basic qualification for young people under the age of 18, who have finished compulsory education but have not yet obtained a basic qualification certificate: at least a certificate at general secondary (havo), pre-university (vwo) or vocational (mbo-2) level. The municipal authorities ensure compliance with the Act in both publicly-run and privately-run schools.

Importantly, not all children between 5-16 need to attend school. In some instances, children can be exempted by the local school attendance officer based on one of the following criteria:

* the child is physically or cognitively unable to undergo schooling;
* parents favour a different outlook on life than the schools located within the area where the parents reside;
* the child is registered at a foreign school (this mainly occurs around the Dutch border zone).

Over recent years, various measures have been implemented to decrease the number of pupils who fail to attend school. In addition, municipalities have been encouraged to become stricter in exempting children from attending school.

**Measures for specific target groups**

*Children living in precarious family situations*

The Dutch government provides school governors and local municipalities with funding to tackle educational disadvantage. The allocation of funding is based on the number of pupils identified as at risk of educational disadvantage. Identification of such pupils includes indicators associated with precarious family situations. The allocation of funding differs per school sector. For example primary schools partly receive funding based on the parents’ highest education degree and the postcode area where the school is located. In 2019, this system was replaced by a system based on a combination of (socio-economic) characteristics of children, their parents, the local area and the school.

Secondary schools receive funding depending on the number of pupils from postcode areas associated with a strong presence of low-income households, households receiving social welfare support, and non-western immigrant households.

*Children of recent migrants and refugees (Cited from Klaver et al., 2016)*

Minor children of asylum seekers, regardless of their status, are entitled to education. Within 3 months after arrival in the reception centre children aged 5-17 have to be enrolled in a school. Many reception centres have their own primary school but also designated regular schools receive refugee children. Generally, special classes are formed at these schools for a period of one year in which the children learn the Dutch language. After this, children are integrated in the regular school classes. Children who have to enrol in secondary education are first placed in an international intermediate class for one year before entering the regular school system. Due to the rapid increase of asylum seekers in 2014 and 2015, the capacity of schools offering education to refugee children was strained. The national government provided additional funding for the provision of education to refugee children.

*Children with disabilities and other children with special needs*

Children with special needs can attend special education. For these children, a dedicated ‘development perspective’ will be drafted with three defined end goals:

* obtaining a certificate;
* finding employment;
* engaging in social activities.

Special primary schools (*sbo-schools*) are for children up to the age of 14 with special cognitive needs, children with special behavioural needs and special needs in their upbringing in general. Children attending special primary schools will follow the same curriculum as their counterparts in mainstream primary schools, but at a slower pace. After attending sbo-schooling, children can either enrol in a general secondary school, or a special secondary school, or a vocational school.

Special education comprises four different ‘clusters’:

* cluster 1: education for pupils with visual impairments;
* cluster 2: education for pupils with hearing impairments or communicative disabilities;
* cluster 3: education for pupils with physical, intellectual and multiple disabilities, and chronically ill pupils;
* cluster 4: education for pupils with behavioural disorders, for pupils with severe disabilities, chronically ill (psychiatric) pupils.

The overall national education policy aims to offer general schooling as much as possible to all children (Education that Fits Act, 2014). Special education schools and general schools generally collaborate at regional level to offer the right schooling to every child.

**Assessment and conclusions**

In the Netherlands, all children have the right to free education and are by law required to receive schooling. The current school system aims to offer appropriate schooling to every child within their local area and schooling that meets the child’s (and parents’) needs. In general, children receive high quality education tailored to their needs. However, inspection bodies and advisory boards do highlight some concerns. A summary of the key concerns for each target group is provided below:

1. *Children in precarious family situations*

The Dutch Inspectorate of Education concluded in their most recent (2018a) yearly report on the state of education that: *‘Increasing inequality, major disparities between schools and the high degree of segregation show that the collective interest is all too easily subordinated to individual or organised group interests. There are still many children in the Netherlands temporarily not receiving any form of formal schooling; problems with the labour market or shrinking communities are regularly left to the market to solve and it is up to the local authority where you happen to live to determine what additional educational support provision you are entitled to receive.* […] *In primary education, segregation is relatively clear-cut. Parents tend to choose schools with pupils from the same background as their own. […] University-educated parents, in particular, are more likely to send their children to schools already populated by pupils with a similar background. Segregation by parental income is also growing, although ethnic segregation is declining. And the extent of segregation varies widely by district.’*

1. *Children of recent migrants and refugees*

The Education Council of the Netherlands (*Onderwijsraad*) argues in their report ‘Refugees and Education’ (2017) that *‘the asylum policy should give greater priority to education, and that refugees should be offered a good level of basic services. [….] Refugees will continue to come to the Netherlands, sometimes in unexpectedly large numbers; the education system is currently inadequately prepared for this, leading to unacceptable delays in organising educational provision when refugees arrive in large numbers. […] There are three areas of inefficiency in the teaching of refugees. First, their school careers are repeatedly interrupted or even halted due to the many times they have to move home during the asylum procedure. Second, there is too little sharing of knowledge in schools where refugees are first enrolled. Third, ad hoc policy creates all kinds of costs, with each region devising their own solutions when educational provision has to be organised quickly for large groups of refugees.’*

1. *Children with disabilities and other children with special needs*

The Education Council of the Netherlands (2018b) recognised the need for strengthening schooling for children with special needs. For example, available special schooling is limited and the regional partnerships between key stakeholders need to be improved.

The Education Council recommends increased efforts to expand special education provision for children with complex needs, such as children with autism, enabling them to attend higher school levels, and children with severe psychological or behavioural needs and severe cognitive needs. In order to expand special education provision, the council advises stronger partnerships between the education sector and youth health care sector.

Another noteworthy concern is related to regional discrepancies in the organisation and implementation of special education. These discrepancies are partly a result of the decentralisation and shifting of responsibilities to local partnership levels. The Education Council acknowledges that local responsibility will enable more local and tailored solutions, but it has also led to discrepancies between regions. Therefore, the Education Council recommends monitoring these discrepancies and addressing this issue when developing a renewed special school system.

## Description and assessment of main policies in place and recommendations for improvements to ensure access to free health care

**Health care for children in the Netherlands**

In the Netherlands, access to health care for children up to the age of 18 years is largely subsidised by the government. The Health Insurance Act (*Zorgwet*), Youth Act (*Jeugdwet*) and Long-Term Care Act (*Wet langdurige zorg*) are important key pillars in the Dutch health care system for the provision of health care services, including youth health care. Through these acts, children can access – for free – basic and essential health care services within the municipalities and the wider region where they reside. A brief description of each act is provided below:

1. Health Insurance Act

As introduced in 2006, the Health Insurance Act requires all residents in the Netherlands to obtain a basic health insurance plan. The insurance will then provide residents (including children) with access to basic medical care services and medications, such as:

* medical care provided by GPs, medical specialists (consultant physicians) and obstetricians;
* hospitalisation;
* mental health services;
* dental care;
* services provided by various types of therapists, including physical therapists, remedial therapists, speech therapists and occupational therapists.

The central government is responsible for the content and size of the statutory health insurance package and reviews it on a yearly basis (Ministry of Public Health, Welfare and Sport [VWS], 2016). The government is informed by a national Health Care Institute (*Zorginstituut Nederland*) to determine the type of care to include in the package.

The Dutch government covers the costs of basic health insurance for children up to age 18, but they have to be included in one of the parents’ plans (Kroneman et al., 2016). Moreover, if parents choose supplementary health insurance packages, they can often include their children in their supplementary plan free of charge. Low income households cannot apply for subsidy support when purchasing a health insurance plan. However, they can be eligible for the Participation Act which serves as the – means-tested – Dutch safety net. It provides a minimum income to anyone legally residing in the Netherlands who has insufficient means to cover the basic costs of living.

Financial penalties apply to people aged 18 years and older who fail to arrange a health plan, with the exception of people who refuse a health plan based on religious beliefs or philosophy of life, and to undocumented migrants (VWS, n.d.). A government body called CAK monitors the registration of people who fail to arrange a health plan. CAK also has processes in place for contacting these people and requesting them to arrange a health plan. Not having a health plan can eventually lead to financial penalties over a six-month period. If a plan is still not being arranged, the CAK will arrange a plan on behalf of the person for a 12-month period. The health insurance premium will then be deducted from the person’s income: either through the individual’s employer or (when on government benefits) through the national social security agency (SVB) (Kroneman et al., 2016).

1. Youth Act

As described in Section 3.0, the Dutch social and health care system has undergone a major transformation by shifting key responsibilities and tasks from national level to municipalities at local level. This change included the implementation of the new Dutch Youth Act in 2015 for children, adolescents and their parents. Under this act, local authorities are responsible for providing access to health care services, ranging from general prevention to specialised voluntary or compulsory care. However, ongoing care is covered by the Long-Term Care Act (VWS, 2016). Within each municipality, access to child health care is usually provided through three local ‘entry points’:

* general practitioners (GPs);
* local multidisciplinary health care teams that operate within each municipality;
* Youth and Family Centres (*Centra Jeugd en Gezin*)located in each municipality.

All three services connect children and their families to specialised care and primary youth care services, including child health care, general social work and child protection services (Hilverdink et al., 2015). In addition to the above three services, schools are also important ‘gateway keepers’ to child health care services, and they often work closely with local health professionals, such as members of local health care teams and social workers.

1. Long-Term Care Act

In 2015, the Long-Term Care Act replaced an existing act (the General Exceptional Medical Expenses Act[[9]](#footnote-10)) for residents (including children) in the Netherlands who require permanent or 24-hour home care. The Long-Term Care Act is a compulsory health insurance policy; those paying income tax will pay premiums under this act (VWS, 2016). The same exemptions apply as with the Health Insurance Act (Kroneman et al., 2016)

Accessing care under this act requires contacting the Care Needs Assessment Centre (*Centrum Indicatiestelling Zorg*) which will undertake an assessment to determine the type of care that is needed. Following the assessment, the Care Needs Assessment Centre will refer the individual to a regional care office (*zorgkantoor*). This office further discusses with the individual the necessary care and oversees the provision of long-term care. There is a total of 32 regional care offices located across the country (Kroneman et al., 2016).

The central government is responsible for overseeing the quality requirements which the providers under the Long-Term Care Act must meet. In addition, several government agencies are responsible for supervision, such as the Dutch Healthcare Authority (*Nederlandse Zorgautoriteit)*, the Dutch Health and Youth Care Inspectorate (*Inspectie Gezondheidszorg en Jeugd*) and the Authority for Consumers and Markets (*Autoriteit Consument en Markt*) to oversee competition in the health care sector (Kroneman et al., 2016).

**National health programmes**

The Dutch health care system offers a range of health services that are available to *all* children (up to the age of 13 years) residing in the Netherlands, namely:

* a prenatal screening programme for pregnant women to detect increased risks of birth defects;
* a heel prick test for young infants to detect a number of rare and severe diseases;
* a hearing screening test for young infants to detect hearing deficits;
* vaccination services as part of the National Immunisation Programme (RPV) to children aged 0 to 13 years old;
* health checks as part of a national health screening programme to children aged 0 to 11 years old.

The above health care services are non-compulsory, mainly focused on preventative health care and subsidised by the central government (participation does not involve any costs). The programmes are overseen and monitored by the Dutch National Institute for Public Health and the Environment (RIVM) and locally administered by midwives’ practices, baby and toddler clinics, municipal health service centres, Youth and Family Centres and local community health services.

With the exception of refugee children, the Dutch health care system does not offer specific health care programmes to one of the FSCG target groups. However, for refugee children, some national measures exist. For example, during the asylum seeking procedure, the Dutch government and health insurer Menzis are responsible for the provision of housing, food and health care services including financing the health care insurance premium for refugee children and adults aged 0 to 25 years. After children are being placed in an asylum seekers’ centre (located in municipalities), the Dutch Central Agency for the Reception of Asylum Seekers (COA) and the local municipality are responsible for providing access to child health care services to refugee children and for monitoring their overall safety and wellbeing. On behalf of the Ministry of Health, Welfare and Sport, the local community health services (in Dutch called ‘GGDs’) are carrying out specific preventative health tasks among refugee children aged 0 to 19 years. These tasks include conducting health screening intakes and periodic health checks and determining the need for a vaccination plan in accordance with the National Immunisation Programme.

**Assessment**

1. Inequalities in health outcomes

Notwithstanding the availability of free basic health care services to all children residing in the Netherlands, there are inequalities in health outcomes among young people in the Netherlands.

Research has shown that in the Netherlands, people with a lower socioeconomic status (SES) have poorer health outcomes than those with a higher SES and higher education levels (Kroneman et al., 2016). For example, between 2014-2016, the life expectancy of people from low income groups was estimated at 51 years, whilst this was estimated at 65 years for people from higher income groups. Moreover, people with higher incomes generally report being in good health more often than people with lower incomes (CBS, 2018).

As the TGs are overrepresented in the low SES-group, they also have poorer health outcomes. This can be illustrated by the TGs’ relatively high level of unmet medical needs in the Netherlands (Inception Report, 2018, p.63).

1. Weaknesses in accessing health care services

Importantly, evaluation outcomes on the implementation of the Youth Act highlight that the renewed child health care system has led to discrepancies at local level in how children and their families can access health care services (Folsche et al., 2018). Local municipalities work with different implementation of health care models, leading to different pathways and processes for their residents when accessing health services (ibid.). Moreover, interviewed experts also raised concerns with longer waiting lists for youth to access appropriate care, an increase in complex health issues and needs among families and children and a lack of specialised expertise within municipalities to address complex multi-problem health cases. Evaluation outcomes also stress that the implementation of the Youth Act is still in its infancy, and that municipalities need more time to review, refine and strengthen their approach in embedding child health care services in their local areas.[[10]](#footnote-11)

1. Weaknesses in affordability

Another important note concerns out-of-pocket payments which are not insignificant, and which have increased in recent years (van Waveren et al., 2018). The legally mandated annual co-payment (*eigen risico*) per adult is estimated at €385, which means that the insured pays the first €385 of the cost of all services subject to the co-payment. However, GP care, pre-natal care and pregnancy care are exempt from the co-payment, and there is compensation for those with chronic illnesses. Several services (hearing aids, etc.) require specific co-payments (unless covered by supplementary insurance). Within this context, rising health care costs are also of concern and may affect low-income households disproportionately, because they pay a larger share of their income to the health care system (ibid.).

**Conclusion**

In light of the above context, the current Dutch main health care policies and programmes lead to a ***moderate security*** of ensuring that the four target groups (TGs) as specified for the FSCG have access to health care. Overall, the Dutch health care system provides free access to health care services to children by subsidising the basic health insurance coverage. However, children need to be included in their parents’ health care plan to access health care services, and the parents’ insurance premium is not being subsidised by the Dutch government. Within this context, rising health care costs are of concern and may affect low-income households disproportionately, because they pay a larger share of their income to the health care system. Low income households can apply for subsidies that fall under the Participation Act that serves as a Dutch safety net to provide a minimum income to anyone legally residing in the Netherlands with insufficient means to cover the basic costs of living.

Recent evaluation outcomes of the renewed child health care system in the Netherlands also highlight that the child health care system is still in its infancy, and that local municipalities work with different implementation models. These differences lead to discrepancies at local level in how children and their families can access health care services. Importantly, these results imply differences in quality of child health care, depending on where the child resides. Noteworthy weaknesses in the current health care system for children include longer waiting lists to access appropriate care, an increase in complex health issues and needs among families and children and a lack of specialised expertise within municipalities to address these complex health needs appropriately.

Moreover, vulnerable population groups in the Netherlands, including low SES-households and non-western migrants show poorer health outcomes than their counterparts. The Dutch health care system partly addresses this gap by specific health care measures for children of recent migrants and refugees. However, no other specific national health programmes are in place for the remaining FSCG target groups.

## Description and assessment of main policies in place and recommendations for improvements to ensure decent housing

Committing to the Convention on the Rights to the Child entails that the Dutch government has to ensure that all children in the Netherlands have access to housing (see Chapter 3.1). Housing policies in the Netherlands are focused on the accessibility and affordability of housing for adults, thereby indirectly affecting children.

The Housing Act (*Woningwet*) recognises that affordable housing in the Netherlands is a shared national responsibility. This includes the availability of affordable rental accommodation and owner-occupied homes for those on relatively low incomes.

According to the ESPN country profile 2017-2018, the Dutch rental housing stock currently consists of approximately 3,273,000 homes. The construction of new houses is on the rise. For 2019-2022, a production of around an average of 70,000 homes per year is expected. Soaring prices in the building sector are, however, increasingly threatening the financial feasibility of these ambitions.

The main stakeholders in the field of housing are the central government, the municipalities, major housing corporations, the Dutch federation of housing corporations AEDES and the Housing Union (*Woonbond)*, which defends the interests of tenants and tenant organisations.

**Home ownership**

Sales prices rise and sales on the housing market in the Netherlands are increasing. Home prices rose by 21% between 2013 and 2017 (Ministry of Home Affairs, 2016). Major cities such as Amsterdam, The Hague, Utrecht and Rotterdam, as well as medium-sized cities like Groningen and Eindhoven, are witnessing stronger house price rises than the rest of the Netherlands (Hekwolter of Hekhuis et al., 2017). As a result, sales are decreasing, in particular in the lower price ranges (NVWM, n.d.).

Given the increase in the number of households in the years to 2020, rising tension on the housing market is expected. A large part of the Dutch housing market is financed by loans: most households take out a mortgage to buy a property. The revival of the housing market is therefore accompanied by an increase in mortgage production (DNB, 2017).

**The rental sphere**

Social housing associations are the main suppliers of regulated rental homes: they supply over 90% of all regulated rental homes (Ministry of Home Affairs, 2016). While maintaining their social commitment, social housing organisations in the Netherlands are financially independent from the central government.

In 2019, social housing is limited to homes for which the initial monthly rent is under the rent limit for liberalised tenancy agreements (*aftoppingsgrens*); the current limit is €720.42. Social housing is destined for vulnerable households and people who are elderly, disabled or have a yearly income under €38,035.

Tenants on low incomes are entitled to housing benefit (*huursubsidie*) if their rent is relatively high (ibid.). There are two types of tenancy agreements; a fixed-period or an indefinite period agreement. Indefinite rental contracts can only be terminated by the landlord if there are legal grounds for termination (rent protection, *huurbescherming*). The rent tribunal (*huurcommissie*) handles disputes about rent levels, maintenance or service charges for social housing. Free sector tenants can make use of the rent tribunal’s rent assessment service (ibid.).

**Quality of housing**

Art. 23 of the Dutch Constitution establishes that it shall be the concern of the authorities to provide sufficient living accommodation, not only in terms of quantity (enough housing) but also in terms of quality (decent housing). The Housing Act (1902) stipulates that dwellings may not pose danger to its inhabitants in any way. The Dutch government developed a building code (*bouwbesluit*), in which minimum requirements to buildings are specified in terms of safety, health, size, usability, sustainability and energy use. Local authorities inspect new and existing buildings to ensure that these requirements are met.

**Affordability and access**

Between 2010 and 2016 inequality with regard to housing costs in the Netherlands grew to a significant degree. This inequality can be explained by an increase in the proportion of poor households’ income spent on housing cost (47.8% in 2017, according to FEANTSA, 2018). Several national and municipal policies had a negative effect on the availability of social housing.

The Netherlands sees a structural decline in the number of social housing units. Following the 2010 EC conclusion that social housing corporations receive state-aid and thus should restrict their services to Services of General Economic Interest (SGEI), the national government limited the activities of the housing associations in the free market (Hoekstra, 2017). Additionally, the government has created more opportunities for housing associations to sell housing stock to private investors.[[11]](#footnote-12)

Research by the ING bank (2017) points out that dwellers who are in social housing do not have a financial incentive to move out. Consequently, people who apply for social housing for the first time end up on a waiting list. It can take years before they are allocated a rent-controlled property. Over the course of the past years, waiting times have increased in most regions. The government tries to stimulate diversified allocation by allowing the housing corporations to increase rents according to household income, with little or no effect. As a result, newcomers to the waiting list have no direct access to social housing, unless they acquire a certificate of urgency (*urgentieverklaring*).

Local authorities decide the requirements for obtaining a certificate of urgency, facilitating access to social housing to those who are forced to find another home as a result of calamity, forced relocation or divorce. The question whether applicants have children or not is taken into account when granting a certificate of urgency.

**Current national programmes for specific target groups**

*Debt and housing exclusion*

Municipalities and corporations have (local) programmes to prevent housing exclusion as much as possible. Nevertheless, it does occur that tenants – with and without children – who are in a vulnerable situation that is deemed ‘preventable’ (for example when someone is not able to pay their rent because of debt) can be evicted from their homes.

Households can also be cut off from utility services (water and energy) when failing to pay their utility bills. Households have to apply for debt counselling in order to prevent cut-offs. In these situations, children are dependent on their parents to take action.

The ESPN country profile 2017-2018 reports that the annual number of home evictions in the Netherlands decreased by 31% between 2013 and 2016 (see also: Aedes, 2017). Most evictions are due to rental arrears (85.1% in 2016). Most housing associations do not keep records on types of households that are involved. Among associations that do keep records of the types of households, figures indicate that 10% of the home evictions involve households with children. The age of these children is not recorded in those statistics. Children who become homeless without parents, fall under the responsibility of youth care services.

Defence for Children Netherlands warns that the rights of children are often overlooked when parents are evicted. Children are sometimes (temporarily) separated from their parents, placed in a volatile and unstable living situation (such as a shelter) or cut off from their social networks and/or school (Bahlmann, 2018). This can lead to stress and insecurity and detriments the child’s wellbeing. Defence for Children concludes that separating children from parents who have become homeless does not comply with the Convention on the Rights to the Child and should be avoided in any way possible.

*Homelessness*

Statistics on homelessness are not very precise, because homeless people are not always registered. According to research by the European NGO FEANTSA (2018), 60,120 people were residing in homeless accommodation services in the Netherlands in 2016. Statistics Netherlands estimates that there were 30,500 homeless people in that year. 4,000 children were registered as homeless in 2015.

Since 2015, access to shelter is warranted in the social support Act (WMO). A person who cannot support himself or herself and who has no family or social safety net to turn to, can ask for shelter and help in the municipality in the Netherlands where they have ‘local ties’. The largest municipalities receive financial means from the central government to subsidise services for homeless people in their region. The services for homeless people in the Netherlands are private, non-profit organisations offering different kinds of services and accommodation, such as night shelters, homeless hostels, temporary supported accommodation, women’s shelters and crisis shelters. When there are children involved, youth aid organisations should be notified to monitor the situation.

At the time of writing, there were no national programmes in relation to decent housing specifically targeting children. Disadvantaged groups in general are ensured priority consideration through the municipal certificates of urgency, in which both medical and social considerations are taken into account.

*Children/people with a disability*

The Dutch building code contains some rules regarding the accessibility of new developed buildings. Article 4.24 for example stipulates rules for the accessibility for persons with disabilities to high buildings and larger houses.

The Netherlands committed to the UN Convention on the Rights of Persons with Disabilities which intends to protect the rights and dignity of persons with disabilities. Parents of children with disabilities or other special needs can apply for financial support from the government to adapt their house to the needs of their children.

Studies on living experiences of people with disabilities report that affordable possibilities on the housing market are limited and that often concessions need to be made in terms of location and proximity to schools, family and care institutions (van der Vlist et al., 2016; Netherlands Institute for Human Rights, 2017).

*Children/people with a migration background*

In 2018, 20,353 people applied for asylum in the Netherlands (Dutch Council for Refugees, 2019). 1,225 of them were unaccompanied minor asylum seekers (UMAs).

People waiting for a residence permit, reside in asylum centres. UMAs below the age of 15 are placed in foster care, where they stay until family reunification, their 18th birthday, or repatriation to the country of origin.

Municipalities are obliged to ensure housing for immigrants in the Netherlands who acquired a residence permit. This group is offered social housing through a certificate of urgency. If a newcomer does not accept the first offer, he/she will be put on the waiting list. A change of law in July 2017 offered more flexibility in municipal priority considerations. The housing market in most areas in the Netherlands is so tight that some local governments change the regulations to give priority to other vulnerable groups. Migrants are offered temporary housing instead.

**Assessment and conclusions**

Looking at the policies described above, we can conclude that the Dutch government has several policies to ensure that the quality of housing meets national health, safety and sustainability standards for its citizens. The social housing system ensures that households have access to affordable rental houses (social housing). Furthermore, people with low incomes may be entitled to rent allowance. Even though these policies are in place, the housing market is causing serious issues in terms of availability of affordable housing. This results in long waiting lists for social housing.

The Dutch main policies focused on housing leads to a **moderate security** of ensuring access to decent housing for the TGs. By this, we mean that children are neither left to their own devices, nor are they specific target groups in housing policies. Housing policies are aimed at adults. Sometimes, this results in children being the victim of their parent’s situation. In this sense, policies are indirectly affecting children’s rights. The TGs’ limited access to decent housing shows from the disproportional number who suffer from an inadequately warm home and/or housing cost overburden (Inception Report, 2018, p.54-56).

**Availability**: The availability of housing in the Netherlands is problematic. The volume of available, affordable housing is low compared with the needs. As a result of a rising tension on the housing market, the regulations in place increasingly fall short in ensuring that vulnerable groups have access to housing. This problem is most urgent in the urban areas in the Netherlands.

There are several policies in place to ensure that the housing available is of appropriate quality. For the homeless, essential shelter and facilities for health, security and nutrition (access to natural and common resources, safe drinking water, energy for cooking, heating and lighting, sanitation etc.) are available at low costs.

**Accessibility:** Target groups such as immigrants with a residence permit or people who are evicted as a result of calamity can apply for a certificate of urgency for social housing. Other groups end up on waiting lists. People without a residence permit cannot apply for housing.

**Affordability:** Affordabilityhas declined since 2010. The proportion of income spent on housing costs has increased, specifically for low-income households. At EU level, housing is deemed to be unaffordable when housing costs represent more than 40% of the household disposable income. In the Netherlands, this percentage is 47.8% for low-income households.

**Adaptability:** Housing contract rules between landlords and tenants are the same throughout the country. However, local governments have a certain discretionary freedom in allocating social housing to vulnerable groups. This results in a grey area around how local service providers implement measures and policies concerning shelter and care. In that respect, a child guarantee for specific TGs could help to ensure that all local authorities pay special attention to children receiving at least the minimum requirements related to decent housing for children, no matter in which municipality they apply for help.

**Acceptability:** Acceptability is secured through the building code, in which minimum requirements to buildings in terms of safety, health, size, usability, sustainability and energy use are specified. New and existing buildings are inspected by the municipalities to ensure that the requirements are met.

## Description and assessment of main policies in place and recommendations for improvements to ensure access to free early childhood education and care (ECEC)

**Current national policies for a wide audience**

In general, each child from the age of 3 months up to 4 years old, can go to day care. Day care is provided by privately-owned organisations and is only accessible via a financial contribution by the parents. Working parents can receive an income-related allowance for the costs of child care, which is provided by the (national) tax authorities. Municipalities can provide subsidies to non-working parents of children aged 2-4 for supporting them in accessing child care. Subsidy rules may differ between municipalities. In most municipalities parents have to pay a parental, often income-related, contribution.

Dutch municipalities are obliged to provide early childhood education to children aged
2.5-4.[[12]](#footnote-13) (*Voor- en Vroegschoolse Educatie, VVE*).[[13]](#footnote-14) VVE also targets children aged 2.5-6, who are at risk of developing educational disadvantages. VVE-groups for children aged 2.5-4 are provided by day care nurseries. A VVE-group works with a special VVE-programme, aimed at reducing language disadvantages and promoting the child’s socio-emotional, cognitive and motor development.[[14]](#footnote-15)

The municipal authorities determine which children belong to the VVE-target group. The main indicator used is the parents’ (low) education level. Referral usually takes place via the baby and toddler clinic (*consultatiebureau*), using criteria that are set by the municipality.

Municipalities cannot require parents of target group children to enrol their children in a VVE-group. All parents are free to choose a provision for their children or to refrain from using any of the provisions.

It was calculated that 86% of the children aged 2,5-4 attended a child care facility in 2017 (Buitenhek Management & Consult, 2017).

**Measures for specific target groups**

*Children living in precarious family situations*

The Ministry of Social Affairs and Employment (SZW) encourages municipalities to create a so-called SMI (Social Medical Indication) arrangement. Such an arrangement should enable children living in precarious family situations to go to day care by fully subsidising the associated costs for day care. Two kinds of precarious family situations are distinguished:

* When parents experience obstacles in fully caring for their child(ren), such as due to the parent’s health situation.
* When the development, health or well-being of the child is at risk due to the parents’ situation, for instance due to substance abuse.

Most municipalities have such arrangements and provide a subsidy for day care for children living in precarious family situations (De Weerd et al., 2014). The eligibility requirements for accessing this financial support, as well as regulations as to who can apply (i.e. the parent or specific professionals) differ by municipality. However, research shows that in 2014 and 2016, full access to the SMI-arrangement was only limited to low-income households due to an income threshold that local municipalities apply. Moreover, low awareness of the arrangement among employers also prevented eligible parents from fully accessing the arrangement (de Lange et al., 2016). In 2016, the Ministry of Social Affairs and Employment (SZW) was committed to increase awareness of the arrangement and to encourage local municipalities that apply the income threshold to cease applying it (Asscher, 2016).

*Children of recent migrants and refugees have limited access to ECEC*

As stated above, municipalities determine which children belong to which target group for early childhood education. Only 35% of the municipalities with an asylum location have ECEC available for these children (Muller & Kolijn, 2016).

*Children with disabilities and other children with special needs*

In the Netherlands, children with disabilities and special needs can access day care support which is primarily offered through the health system. For instance, children with behavioural problems can attend afterschool care facilities to receive – in a group environment – support in strengthening their social skills (VWS & CAK, n.d.). Children with disabilities aged 0-7 can also access medical child care facilities for care support. A team of health professionals will assess the child’s needs to develop a care plan. Based on the plan, the child may then attend the medical child care facility for receiving appropriate care and support (ibid.).

**Assessment and conclusions**

**Availability:** In the Netherlands, the early childhood education care sector experiences shortages in personnel. As a result, children are often put on waiting list to secure a spot in a day care facility. Metropolitan areas often experience longer waiting lists than other areas, while parents living in more regional areas may sometimes need to commute further to access ECEC facilities. The local municipalities are required to provide access to ECEC facilities within their local area.

**Accessibility:** Overall, all children residing in the Netherlands can access ECEC facilities. However, variations apply in how to access these facilities, depending on the local municipality the child resides. For example, some local municipalities define specific target groups for ECEC facilities, while other municipalities do not define any specific target groups.

**Affordability:** Up until recently, parents of target group children for early childhood education were subsidised through the local municipality. The current system requires parents to first pay for early childhood education themselves and then apply for tax benefits through the Dutch tax agency. There are some indications – mainly in the larger Dutch cities – that the current system has led to a decrease in the number of target group children attending ECEC facilities. Another indication is presented in the Inception Report (2018, p.76), showing that financial reasons are the dominant factor that hamper the use of formal child care services in the Netherlands, more dominant than in most other countries.

**Acceptability:** Children with working parents from the lowest income groups appear to attend less often ECEC facilities than their counterparts from higher income groups. Income could be a driving factor for this differentiation, as well as cultural differences with lower income households often being less positive about early childhood education than higher income households.

## Summary of main weaknesses and priorities for future action as highlighted in Sections 3.1-3.5

Table 2 (below) shows our analysis in which the main barriers/weaknesses are summarised with regard to existing policies/measures to support the access of each of the three TGs.

Table 2: Summary of main weaknesses in existing policies/provision and key priorities for improving policies/provision as highlighted in Sections 3.1-3.5

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Children living in precarious family situations** | **Children of recent migrants and refugees** | **Children with disabilities and other special needs** |
| **Adequate nutrition** | **Main barriers & weaknesses** | 1. The absence of a national strategy to specifically target this target group2. Residential water cut-offs for households that fail to pay their water bills3. Poor health outcome due to less healthy food intake | 1. The absence of a national strategy to specifically target this target group2. Residential water cut-offs for households that fail to pay their water bills3. Poor health outcome due to less healthy food intake | 1. The absence of a national strategy to specifically target this target group2. Residential water cut-offs for households that fail to pay their water bills3. Poor health outcome due to less healthy food intake |
| **Priorities for action** | 1. Design policies to empower children in exercising healthier lifestyle choices2. Reconsider residential water cut-off policies and review current water cut-off practices | 1. Design policies to empower children in exercising healthier lifestyle choices2. Reconsider residential water cut-off policies and review current water cut-off practices | 1. Design policies to empower children in exercising healthier lifestyle choices2. Reconsider residential water cut-off policies and review current water cut-off practices |
| **Free education** | **Main barriers & weaknesses** | 1. Disparities between schools and the degree of segregation2. Relatively large group of children temporarily not receiving formal schooling | 1. Delays in organising educational provision when refugees arrive in large numbers2. Inefficiency in the teaching of refugees. | 1. Insufficient support offer for children with complex special needs2 Regional differences in organisation and implementation ‘appropriate education’ |
| **Priorities for action** | 1. Provide local municipalities with tools to combat segregation in education2. Reduce the number of children temporarily not receiving formal schooling | 1. More efficient organisation of the education of refugee-children | 1. More and more variety in support offer for children with complex special needs2. Further elaboration of governance of regional partnerships ‘appropriate education’. |
| **Free health care** | **Main barriers & weaknesses** | 1. The absence of a national strategy to specifically target this target group2. The accessibility of care and the quality of care may vary, depending on the local municipality where the child resides3. Children mainly depend on the parents’ financial ability to pay insurance to access health care services.  | 1. The accessibility of care and the quality of care can vary, depending on the local municipality where the child resides2. Children mainly depend on the parents’ financial ability to pay insurance to access health care services. | 1. The absence of a national strategy to specifically target this target group2. The accessibility of care and the quality of care may vary, depending on the local municipality where the child resides3. Children mainly depend on the parent’s financial ability to pay insurance to access health care services.  |
| **Priorities for action** | 1. Provide local municipalities with the right tools and knowledge to provide appropriate health care services to children and families with complex health needs | 1. Provide local municipalities with the right tools and knowledge to provide appropriate health care services to children and families with complex health needs | 1. Provide local municipalities with the right tools and knowledge to provide appropriate health care services to children and families with complex health needs |
| **Decent Housing** | **Main barriers & weaknesses** | 1. Insufficiently available social rental housing2. No general policy for families with children in case of eviction caused by, for example, debt problems. Home evictions may be prevented through early detection by social neighbourhood teams3. In case of home eviction children are sometimes separated from their parents if there is no emergency family accommodation available  | 1. Insufficient availability of social rental housing: priority for immigrants is being questioned | 1. Due to scarcity of suitable housing people have limited influence on where they live. Nearness of family / school is therefore no longer self-evident |
| **Priorities for action** | 1. Ensure sufficient available housing so that waiting lists decrease2. Share knowledge among social neighbourhood teams in order to be able to supply appropriate preventive local services that are tailor made | 1. Ensure sufficient available housing so that waiting lists decrease | 1. Ensure sufficient available housing so that there are more options |
| **Free ECEC** | **Main barriers & weaknesses** | 1. Differences in access to facilities among local municipalities2. Waiting lists due to shortages in personnel 3. Indications that the system of subsidising parents leads to a decrease in the number of target group children attending ECEC-facilities | 1. only 35% of the municipalities with an asylum location have ECEC available for these children | No specific barriers |
| **Priorities for action** | 1. More unity in access regulations2. Labour market measures to prevent waiting lists | 1. ECEC facilities in more municipalities with asylum seeker centres |  |

## Description and assessment of main policies in place and recommendations for improvements to the situation of children residing in institutions

Summary: Regulations and policies are designed to prevent the out-of-home placement of children as much as possible by means of (specialist) support in the home situation. If out-of-home placement cannot be prevented, the policy is that family-oriented care is preferable to residential care. However, practice is unruly. Serious problems are often identified too late and there is insufficient availability of specialist assistance in the home situation.

**Out-of-home placement is an ultimum remedium, a last resort**

The Netherlands acceded to the International Convention on the Rights of the Child (CRC). Under the CRC, the government must ensure that the parents' responsibility to bring up their children is respected. In addition, each child has the right to grow up with their parents and to keep in touch with both parents if they live separately from one or both parents, unless this is contrary to the best interests of the child.

Since 1 January 2015, when the Youth Act (Staatsblad 2014, nr. 105) came into force, municipalities have become responsible for all forms of youth care, child protection and juvenile probation. Residential youth care is a form of assistance in which children or youngsters are (temporarily) placed out of their homes on a voluntary or compulsory basis, and placed in residential groups and treatment groups. There are various forms of residential youth care: independent living training, residential groups focused on behavioural skills and growing up, treatment groups focused on the treatment of specific problems, crisis relief and closed residential youth care.

The Youth Act includes preconditions and quality requirements that youth care and/or youth care providers must meet, such as file creation, a plan (assistance plan, treatment plan) and quality monitoring and control.

The system change is aimed at realising a number of transformations. The transformation goals include prevention, discovering one’s own possibilities, demedicalization, unburdening and normalization, and appropriate tailored help at an earlier stage. It is assumed that when more attention is paid to prevention and appropriate tailored assistance, this will prevent problems from worsening, which would require specialist help, including residential care. The Youth Act aims to stimulate children to grow up in their own home environment as much as possible.

In addition, the Directive on out-of-home placement for youth care and youth protection is based on preventing out-of-home placements as much as possible and on using ambulant interventions instead.

**If out-of-home placement cannot be prevented**

In some families where parenting or upbringing problems occur, these problems are so large that a child has to be temporarily or permanently placed out-of-home and separated from their parents or guardians. A child who is temporarily or permanently removed from his family is entitled under the CRC to special protection and assistance from the state. In the case of out-of-home placement, the state must provide a suitable alternative, taking into account the background and special needs of the child. There is a hierarchy in the alternatives of care. First of all, it must be checked whether the child can live with other members of the family in a broader sense (placement in the network), then whether a replacement family (foster family or group home) is a possibility and lastly, only if there is no other alternative, a suitable residential institution.

The Youth Act also stipulates that children and youngsters who can no longer live with their own parents, are placed in a foster home or in a group home. For this reason, the municipal executive is explicitly instructed to give preference to placement in a family environment over placement in an institution in the event of an out-of-home placement. In order to assist municipalities with this responsibility, the 'Youth care in family forms' project started in the autumn of 2016. In the project, a guide and framework for setting up youth care in family forms has been developed for municipalities.

The first evaluation of the Youth Act shows that in practice it is difficult to fulfil this obligation because of an insufficient number of foster parents. This problem is addressed in the Youth Care Action Plan, which was presented to the House of Representatives by the Ministers of Health, Welfare and Sports (VWS) and Justice and Security (JenV) on 16 April 2018. One of the action lines of the Action Plan is 'letting more children grow up in home-like circumstances'. In this action line a number of policy measures are mentioned, namely:

* + youth care organisations are instructed to further develop themselves in the field of prevention of unsafe home situations;
	+ support care in foster families by means of the Foster Care Action Plan;
	+ develop an approach to minimize the number of times children are transferred from one foster family to another;
	+ fewer placements in Youth Care Plus (secure residential youth care in the context of child protection), shortening the duration and promoting outflow;
	+ stop secluding children and reduce other temporary separation as much as possible.

**Table 3: Summary of main weaknesses in existing policies/provision and key priorities for improving policies/provision (children residing in institutions)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
| **Children residing in institutions** |
| **Main weaknesses in existing policies & provision** | 1. Policy and practice do not match: the policy is based on the prevention of out-of-home placement, but in practice serious problems are not identified in time and/or specialist assistance is insufficiently available in the home situation 2. (Still) no policy to prevent the transfer of children |
| **Priorities for action** | 1. Promoting expertise within social neighbourhood teams, so that timely referral is made to specialist assistance2. Ensuring sufficient appropriate specialist assistance |

 |

## Assessment of integrated, comprehensive and strategic approach[[15]](#footnote-16)

The most important development in recent years is that anti-poverty policies have increasingly focused on the position of children. In the fall of 2016, the cabinet allocated an annual amount of EUR 100 million for the fight against child poverty for the period to come (Klijnsma, 2016a). 85 million of this budget is allocated to municipalities. It is intended for the provision of in-kind facilities. For the implementation of this policy, it is necessary to cooperate with civil society organisations that have the expertise to effectively reach the children.

In general, this policy development is in line with the Recommendation. With regard to monitoring, it must be observed that there are no quantitative targets on the extent to which and the rate at which child poverty must be combatted. This appears to be a weakness because it impedes effective monitoring of the policy (SER 2017, p 69-70). This is important now that it has been established that, despite the policy commitment, the extent of child poverty has not yet convincingly decreased.

*Integrated multi-dimensional strategy; synergies between relevant policy areas and players*. In both Letters to Parliament (Klijnsma 2016a and 2016b), the State Secretary argues that cooperation between municipalities and civil society organisations would greatly enhance the effectiveness of the policy. She mentions five specific civil society organisations that are very successful in reaching children and allocates part of the available funding just for this purpose. She also insists on intensified cooperation between municipal departments. Regarding further elaboration of the policy, Administrative Agreements have been made between the government and the representative of the Dutch municipalities, The Association of Netherlands Municipalities (VNG).

*Good balance between universal and targeted policies and sufficient focus on children at increased risk because of multiple disadvantages*. Dutch social policy has been ‘universal’ in character for a long time, also before 2013. The SER adopts a critical attitude towards this: the current (child) poverty policy is insufficiently effective (SER 2017, p 60-61). In addition, the reach of the policy is far from optimal.

*Involvement of relevant stakeholders; effort to support the involvement of children themselves*. The VNG and the five civil society organisations have been involved in the process of policy elaboration; the cooperation is laid down in Administrative Agreements (between the government and the VNG); and the five organisations have described the contours of their contributions. Both documents were enclosed in the Letter to Parliament (Klijnsma 2016b). Children are also involved in the policy process. At ten primary schools, the State Secretary will discuss with the children (up to 12 years) how to best spend the additional budget (100 million) for child poverty reduction. Something similar is organised for older children (Klijnsma 2016b, p 3).

*Evidence-based approaches and assessment of the impact of policies introduced in response to the crisis on children*. Since 2013, the cabinet has commissioned various studies on child poverty, recently a study was conducted by the Dutch Ombudsman for Children (*Kinderombudsman*) (not yet published) and the SER. The SER report, published in March 2017, is critical of the effectiveness of the policy pursued and recommends the cabinet to improve the policy effectiveness (SER 2017, p 60). The SER insists on the promotion of evidence-based working and on conducting more research into both policy execution and the stakeholders themselves (SER 2017, p 56). In addition, it is important that the Administrative Agreements also stipulate that the parties involved develop and exchange best practices together (Klijnsma 2016b).

*Respect for children's rights and attention for vulnerable groups*. Most Dutch social policies are generally targeted; there are no specific target group policies. An exception is that there are specific facilities for the children of asylum seekers to help them find their place in Dutch society as quickly as possible.[[16]](#footnote-17)

## Costs of five rights

There is some general research available on the costs of a child in the Netherlands.

The CBS (2018) determined the costs of children on behalf of the Ministry of Social Affairs and Employment. A second useful source is Nibud (n.d.), which makes available material that can show the costs of children.

One child costs on average 17% of the disposable income. Two children cost an average of 26% of the income, three children 33% and four children 40%.

# Use of EU Funds

## Extent of use[[17]](#footnote-18)

The Dutch ‘ESF Annual Implementation Report 2014-2020 – Implementation years 2014 and 2015’ (Agency of Social Affairs and Employment [Agentschap SZW], 2016) states the following with regard to using the budgets:

‘*In 2014, ESF 2014-2020 started by publishing the subsidy scheme ESF 2014-2020 on
31 March 2014. The Netherlands chose to focus on using its available means on the following two themes:*

* *promoting social inclusion and combatting poverty and discrimination;*
* *promoting sustainable and high quality employment and supporting labour mobility.*

*With regard to the first theme, ESF funding is used to reduce youth unemployment and to invest in the reintegration of people with an occupational disability, unemployed over fifty years old, unemployed people who do not receive benefits, including (low-skilled) women. This theme also includes removing language deficiencies. In addition, part of the ESF funds are used to support (former) students of secondary special education and labour-oriented practical training. They receive extra support to obtain a basic qualification and job placement support. With regard to the second theme, efforts are made to keep people productively employed longer and to stimulate age-aware personnel strategies by means of ESF.*’

Table 4 shows the extent to which the Netherlands can fall back on and uses European funds. The table, based on data from ‘Operational Programmes Financial Plan and Implementation by Investment Priority (20 April 2017)’ shows that:

- the Netherlands has budgets for priority 8 (employment: 25 million, active and healthy ageing: 101 million) and priority 9 (active inclusion, 361 million), but not for priority 10 (education);

- within all priorities the Netherlands co-finances 50%, i.e. EU contributions are always equal to contributions from the Netherlands (column F in table 1 below);

- with regard to all priorities the Netherlands spends (a fraction less than) half of the EU budget available (absorbing rate, column E).

**EU-funds and the TGs in the Netherlands**

The consultation of the managing authorities and the analysis of project documentation show that none of the projects undertaken are directly targeted to the TGs. This leads to the conclusion that the Netherlands does not use EU-funds for the direct benefit of the TGs on the PAs under scrutiny.

**Table 4: Financial overview (budgets, expenses, declarations; by thematic objectives)**



Source: Operational Programmes Financial Plan and Implementation by Investment Priority (20 April 2017)

## Effectiveness

This theme is not relevant, since the Netherlands does not use the EU-funds for the direct benefit of the TGs on the PAs under scrutiny.

## Improvements

We advise the managing authorities to evaluate the use of EU-funds – and the non-use for the four TGs, thereby taking account of the outcomes of this study on (shortcomings in) the delivery of services for the four TGs. Suggestions for improvement of policies and/or provision of services are mentioned in tables 2 and 3.

**Table 5: Priorities for future use of EU Funds[[18]](#footnote-19)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Children living in precarious family situations** | **Children of recent migrants and refugees**  | **Children with disabilities and other special needs** | **Children residing in institutions** |
| **1. Adequate nutrition** |  |  |  |  |
| **2. Free education** |  |  |  |  |
| **3. Free health care** |  |  |  |  |
| **4. Decent housing** |  |  |  |  |
| **5. Free ECEC** |  |  |  |  |
| **6. Strategic weaknesses in the way EU Funds are currently used for supporting the 4 TGs** |  |
| **7. Organisational priorities for improving the ways EU Funds are used for supporting the 4 TGs** |  |

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# Interviews

* Save the Children
* Defence for Children
* Kinderombudsman
* Managing Authorities: Ministry of Social Affairs and Employment
1. The current system requires parents to first pay for early childhood education themselves and then apply for tax benefits through the Dutch tax authority. [↑](#footnote-ref-2)
2. The main part of this section 2.1 was published earlier in the *ESPN Thematic Report on Progress in the implementation of the 2013 EU Recommendation on “Investing in children: Breaking the cycle of disadvantage”: The Netherlands* (Kruis and Van Waveren, 2017). [↑](#footnote-ref-3)
3. As there are no data available on the subgroups ‘Left behind children’ in the Netherlands, this section is limited to the description of the groups ‘Low income/low SES’ and ‘Children living in single-adult households’ and ‘Roma children’. [↑](#footnote-ref-4)
4. Article 26: no independent right of children to social insurance is accepted; social insurance for children is in many cases a right of the parents. Article 37: it must be possible to apply adult criminal law to children sixteen years of age and older; this is in accordance with current criminal law. Article 40: for minor offences it must be possible to resolve a case without counsel and without appeal. [↑](#footnote-ref-5)
5. [↑](#footnote-ref-6)
6. The Dutch government is committed to decrease the percentage of youth being overweight from 13.5% in 2017 to 9,1% by 2040, and the percentage of youth being obese from 2.8% in 2017 to 2,3% by 2040. [↑](#footnote-ref-7)
7. Based on:

- European Agency for Special Needs and Inclusive Education (2018);

- TIMSS & PIRLS International Study Center (2016);

- Education Council of the Netherlands (n.d.). [↑](#footnote-ref-8)
8. These quality standards are written down in various acts for each type of education: Primary Education Act (WPO), Special education: Expertise Centres Act (WEC), Secondary Education Act (WVO), Adult and Vocational Education Act (WEB), Higher Education and Research Act (WHO). [↑](#footnote-ref-9)
9. In Dutch called the ‘Algemene Wet Bijzondere Ziektekosten (AWBZ)’ [↑](#footnote-ref-10)
10. Friele, R.D., Bruning, M.R., Bastiaanssen, I.L.W., et al., *Eerste evaluatie Jeugdwet*, ZonMw, The Hague, 2018. [↑](#footnote-ref-11)
11. See for example the website of the Ministry of the Interior and Kingdom Relations: <https://www.government.nl/topics/investing-in-dutch-housing/investing-in-rental-market> [↑](#footnote-ref-12)
12. This includes pre-school education. Early school education, for children from 4 to 6 years old, is provided by primary schools. Although children are required to attend primary school when they are five years old, almost all children start at age four. Schools receive extra budgets for children from low-educated parents. [↑](#footnote-ref-13)
13. The central government provides municipalities with funding. Municipalities are free to add extra funding to the VVE-budget they receive. [↑](#footnote-ref-14)
14. In practice, children who are not part of the target group also attend these groups. This is partly desired because target group children are expected to learn from non-target group children. Extra funding has been made available to establish so-called mixed groups. [↑](#footnote-ref-15)
15. The main part of this paragraph is published earlier in: Kruis, G. and Van Waveren, R.C.. *ESPN Thematic Report on Progress in the implementation of the 2013 EU Recommendation on “Investing in children: Breaking the cycle of disadvantage”: The Netherlands.* Amsterdam/Brussels: Regioplan/European Commission, 2017. [↑](#footnote-ref-16)
16. Minor children of asylum seekers, regardless of their status, are entitled to education. Within 3 months after arrival in the reception centre children (5-17 years) have to be enrolled at a school. Many reception centres have their own primary school but also designated regular schools receive refugee children. Generally special classes are formed at these schools for a period of one year in which the children learn the Dutch language from specifically trained teacher. After this year children are integrated in the regular school classes. Children who have to enrol in secondary education are first placed in an international intermediate class for one year before entering the regular school system. [↑](#footnote-ref-17)
17. The main part of this section was published earlier in: *ESPN Thematic Report on Progress in the implementation of the 2013 EU Recommendation on “Investing in children: Breaking the cycle of disadvantage”* by Kruis and Van Waveren (2017). [↑](#footnote-ref-18)
18. See tables 2 and 3. [↑](#footnote-ref-19)