This project is co-funded by the European Union

Quality of jobs and services in the Personal care and Household Services sector in the Netherlands

December 2015

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INTRODUCTORY NOTE

This report has been prepared, reviewed and finalised through the research of its authors, the contributions and suggestions of the project partners, the suggestions and remarks made by the participants-members of partners' organisations at the regional seminars (Rome / Brighton / Vienna 2015) and by the Advisory Board members (AGE Platform, Eurofound). The authors wish to thank warmly all these persons for their time and contribution. The report presents the personal care and household services sector in the country at stake and in the framework of the For quality! project objectives, following the methodological grid validated by the consortium, without being exhaustive. Authors have tried to incorporate corrections and comments that were reported to them during this process. However, the content does not necessarily reflect the vision of the project partners who are not responsible for the information contained in this report.

This publication is supported by the European Union's Programme for Employment and Social Solidarity - PROGRESS (2007- 2013). This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Europe 2020 Strategy goals in these fields.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-28, EFTA-EEA and EU candidate and pre-candidate countries. For more information see: http://ec.europa.eu/progress.

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1. NATIONAL OR LOCAL REGULATION AND POLICIES

1.1. Policy and legal backgrounds

The terminology personal care and household services (PHS) includes many different services to persons and households. In the Dutch context PHS may be provided by people with various employment statuses: employees working for care providers (organisations), self-employed, friends or relatives[1]. Due to the wide range of activities these services are not seen as a coherent economic sector in the Netherlands, and thus there is no general legal definition for it[2]. Also within the statistical databases a single figure to view the trends in this sector is absent. Yet, there is data available for most of the separate elements of PHS.

The Dutch long term care (LTC)[3] policy aims for quality, accessibility and affordability of care. The core philosophy of the system is that the State carries the responsibility for persons who are in need of care. The Dutch public LTC insurance system has been introduced in 1968 - the first in the OECD. It is currently regulated by three important laws: “WLZ”, “Wmo”[4] and “Zvw”.

Firstly, the Long-term Care Act (WLZ - *Wet langdurige zorg*) applies to people who need all day intensive care or require close supervision, for example: older people with advanced dementia

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[1] European Employment Policy Observatory (EEPO), Ad hoc request: Personal and household services - the Netherlands, 2015, http://bit.ly/1LaM2m2.

[2] In the Netherlands, PHS (*persoonlijke diensten*) cover activities such as home activities that an individual can run by itself, or entrust a third party. There are three categories of PHS, each under a separate regulation: the everyday services (DIY, gardening, housework...), services for dependent persons (home care, care for the older people...) and the family services (childcare). The market for PHS is not homogeneous. There are three types of markets:

- Commercial type services financed by private users: the demand and supply determine the price.
- Care funded by the community (using "WLZ and "Wmo"): Market forces play only a subsidiary role, as care allowance results from the estimated need for care for dependent persons.
- Informal care for dependent persons (*mantelzorg*) made without compensation by the immediate environment (family, friends, neighbours ...) or volunteers.

The market for commercial-type services can be divided into formal and informal markets:

- formal market: the supply and demand pass through companies and institutions dedicated to the sector of personal services
- informal market: supply and demand are realised between individuals (family, friends ...).

Source: Kergueris J., Services à la personne: bilan et prospective, Sénat, 2010.

[3] The LTC services are part of PHS. They are composed of formal care at home, formal institutional care and informal care.

[4] The law WLZ has been described thanks in particular to Joost Broumels and Jolanda Verbiesen. The description of AWBZ and Wmo is mainly taken from: Mot Esther, The Dutch system of long-term care, CPB document, n°204, 2010.

or people with severe mental, physical or sensory impairment.

The WLZ has been introduced on 1st January 2015 and has replaced parts of the Exceptional Medical Expenses Act (AWBZ - *Algemene Wet Bijzondere Ziektekosten*)[5]. Prior to the reform launched in 2014 each Dutch resident was insured under the AWBZ for individual insurable disease cost risks. The AWBZ was covering a broad package of services: personal care, nursing, assistance, treatment and stay in an institution. Assistance includes day care in groups as well as personal (one-on-one) assistance. The assistance aims at allowing people to live independently (for example, help with organising the household or with administration). Assistance also aims to improve social participation: taking walks, going out, etc. The AWBZ was sharing the risks between persons who are more in need of LTC and persons who are less in need. This is possible thanks to the mechanism of LTC premiums and taxes. A lot of LTC legislation has been changed in 2014, moving to greater decentralisation of responsibilities from the central state to the municipal level. Since 1st January 2015 municipalities have become responsible for child welfare, employment and income and care for chronically ill and the older persons.

Overall, since 1st January 2015 the new WLZ has brought four major changes:

- Support at home is now a task of the municipality. Examples of home support are: counselling, day care and sheltered housing. This responsibility is stated in the Law on Social Support 2015 (Wmo2015).
- Municipalities are now also responsible for all youth, as stated in the Juvenile law.
- Nursing and care at home is part of the basic package of health insurance. Examples of nursing care at home are: administering medications and assistance with showering. This is stated in the Health Insurance Act.
- The state remains responsible for the care of people who need all day intensive care and close supervision. This concern is LTC under the new WLZ. There will be more opportunities to receive this care at home. People who want to care not at home can go to a care facility.

The second LTC most important law in the Netherlands is the Law on Social Support (Wmo - *Wet Maatschappelijke Ondersteuning*), an act pertaining to social services, which is carried out by the local council. The Wmo law regulates the provision of support and household care for disabled, dependent and older persons and has transferred the responsibility from the State to the municipalities of providing household care and support whether in kind or in cash through

[5] Other parts that belonged to the AWBZ have become the responsibility of the municipality and are included in the "Wmo" (read below).

the use of personal budgets (PGB - *persoonsgebonden budget*).

The first step of decentralisation took place in 2007, when domestic care was shifted from the AWBZ to Wmo. A new decentralisation step has been implemented since 1st January 2015 (Wmo 2015) when municipalities have become responsible for:

- Most of all youth care
- Wmo (personal) care and welfare
- LTC is still centralised but al lot of tasks are decentralised in the Wmo
- Law for education
- Law for participation in labour market.

Since 1st January 2015 fewer people receive domestic help from the new Wmo 2015. In 2015 and 2016 therefore extra money is available to municipalities in the form of domestic help allowance (HHT - *Huishoudelijke Hulp Toelage*). The HHT helps to preserve jobs in the household. The HHT helps municipalities to facilitate Wmo-clients to contract domestic help at a lower contribution than the actual cost. The domestic helper is employed by a provider. In order to develop a strong workforce, objectives of the HHT plans and can best determine what is needed regionally or locally to maintain employment and further develop the market for domestic services. It is to be underlined that these changes from 2015 are not specific to Wmo, but that they refer to all legislation which had the effect of municipalities that were given more tasks.

At last, the third most relevant law on publicly funded PHS is the Act health insurance (Zvw - Zorgverzekeringswet;) which activities are coordinated by the health companies. The Zvw arranges the health care and personal care at home[6].

Overall, while the municipalities are now mostly in charge of the execution of the new PHS sector-related legislation, the central government remains in charge of the legislation of the PSH sector. Its goal is to guarantee that the conditions are fulfilled to achieve the policy goals (accessible and affordable care of good quality). Given this general responsibility, many specific responsibilities are laid down at the micro level of private care providers, which are responsible for providing care of good quality and for good governance of their organisations.

In 2012 3.8% of the Dutch GDP was spent on LTC, the largest spending in the EU[7]. The

[6] EEPO, 2015.

[7] In 2007 total AWBZ expenditures were approximately 22 billion € (or 4% of GDP). Source: Mot Esther, 2010.

ongoing reforms try to decrease the public expenditure, but the decentralisation is combined with large budget cuts for municipalities to fund activities in the social domain[8].

As of the privately funded personal care services inside or around the house, around 1 million Dutch households buy these services, offering 272 million hours of work and spending around EUR 2.5 billion per year on such services. This spending includes the individual spending of households plus the spending of third actors such as the government. It means that on average a household buys in 196 hours of services each year. Most of this work (95 %) falls within the legal scope of the Arrangement Service Provision at Home (*Regeling Dienstverlening aan Huis*), determining that such service provision does not constitute an employer-employee relationship as long as the weekly service provision does not exceed four working days.

At last, it should be noted that the child care is a private sector. However, parents are entitled to a tax credit (*Kinderopvangtoeslag*) which refunds parts of their child care expenditure, depending on working hours and household income.

1.2. Structural framework, funding and actors involved

With the WLZ covering both cares at home and in institutions, the LTC is mainly the responsibility of the central government: 32 regional care agencies (*zorgkantoren*) have been assigned to buy care with public funds. People deal with the care agencies in case they receive the LTC. Since 1st January 2015 when the care used has fallen under the juvenile law, it is now the municipality's responsibility. These agencies are generally subdivisions of the leading health insurer in each region[9] and have no personal budget (apart from administrative costs). Care providers are directly paid from a general public fund (AFBZ - *Algemeen Fonds Bijzondere Ziektekosten*) on the basis of contracts concluded with purchasing agencies. Therefore, purchasing agencies bear no financial risk on purchasing care. As described above, the provision of care has been significantly decentralised from the state level to the municipalities (through Wmo, in both 2007 and 2015).

Institutional care tariffs are regulated, while home care prices result from bargaining between purchasing agencies and providers. Institutional care providers must be non-for-profit organisations, while the home care market has been opened to for-profit companies.

Municipalities and NGOs (e.g. insurance companies) can formulate more specific criteria within these general boundaries and are responsible for the organisation of the system. The Dutch government lays down a framework regulation within which municipalities and independent agencies develop their own rules. The independent agencies 'govern' home nursing and

[8] EEPO, 2015.

[9] OECD, OECD Economic surveys: Netherlands 2012.

personal-care services; municipalities regulate domestic aid. Before the reform of 1st January 2015 the Dutch Social Support Act Wmo was providing a general description of municipal responsibilities and requiring municipalities to write down a vision on social support, including domestic aid, every four years. Municipalities decide on eligibility, prices of services and the exact services that will be publicly funded. The Dutch Healthcare Authority sets maximum prices for personal care and home nursing; the Care Assessment Centre (CIZ - *Centrum Indicatiestelling Zorg*) decides on the exact eligibility criteria within the boundaries of the governmental guidelines.

Since the reform of 1st January 2015 the role of CIZ remains only in the framework of the WLZ and not with the Wmo 2015. The Wmo 2015 has a clear definition and is different from the WLZ. Assessment for these areas will therefore be separate and integrally take place or by municipalities or the CIZ. The Wmo 2015 and the WLZ provide a legal framework for data exchange between CIZ and municipalities for implementation of these laws.

The funding of the care system is partly tax-based, under the WLZ and the Wmo, and partly insurance-based. In general, people have to pay a part of the care costs themselves (*eigen bijdrage*), cashed by the CAK (central administration office). Apart from public care, there is also private care.

The Netherlands spends between 1% and 5% of country's health budget on home care. As home care is not always part of the health-care system, large differences are found between social home care and home health care as a percentage of GDP. For total home care this ranges to 0.70% in the Netherlands. The country spends relatively (as a share of GDP) the most on home care.

Long-term funding of the LTC system is becoming a problem. The expenses of LTC (WLZ) in 2013 amounted EUR 28.5 billion (AWBZ and Wmo domestic help). The current policy debate centres on limiting the WLZ entitlements to the most vulnerable persons and the most necessary services. Co-payments are higher for persons with higher incomes.

Since the beginning of 2010, voucher systems are being experimented under the name of "Alfachèques" in several municipalities (Tilburg, Breda, Oisterwijk, Gorinchem)[10], with "alpha-workers" (*alphahulpen*) as the home helpers who work for the care recipient. Instead of providing care in kind, municipalities distribute these vouchers to people entitled to Wmo benefits. According to the personal situation of the beneficiary, the municipality determines the amount of hours and vouchers that the beneficiary is entitled to. The personal budget granted is directly transferred to the beneficiary's bank account. With these vouchers, beneficiaries are supposed to receive the service from worker of their choice. One voucher of €12.80 can be

[10] EFSI, White book on personal and household services in ten EU Member States, 2013.

exchanged against one hour of domestic work. This amount already includes the vacations payment and the paid leave. The beneficiaries may need to pay a contribution per voucher according to their level of income. As a consequence, municipalities can gain €5 to €6 per hour instead of services in kind, as alpha workers' employers are exempted from any social contribution. Alpha vouchers provide better control for the municipalities by guaranteeing the vouchers can only be used to pay for services of Alpha workers. However, the fact that its beneficiaries must prove afterwards how they spent their personal budget, leads to more administrative burden for both users and public authorities. In addition, Alpha workers do not benefit from regular rights and benefits. Last but certainly not the least, the use of Alpha workers is the way to reduce the LTC budgets.

One way to support the development of a strong workforce is to avoid too much use of Alpha home help structures. Alpha workers are not employed in the home care setting, but for the user himself-herself. The employment falls under the regulation "Home service" and therefore it is essential that the conditions of that regulation are fulfilled. This also means that no more than three days per week may be worked by the same client, because the client does not need to pay premiums, helpers are not insured as regular employees and are not insured for disability.

2. WORK AND EMPLOYMENT QUALITY

2.1. Career and employment security

2.1.1. Employment status

The population of the Netherlands is around 16.9 million persons. In 2012, the employed labour force concerned 7.9 million people (15-65 years old), or by around 67.2%[11].

In 2012, the workforce in community-based care for the older and disabled people has accounted 132.200 employed, within there were 2.055 establishments. In 2011, in total 1.348.900 people were employed in the health and social care sector. The branches accounted: mental care 88.000, care for disabled 161.000, home-care services 193.000 and welfare services 72.000 jobs (in total 514.000)[12].

The rising trend of home-care workers is expected to continue in the coming years. The sector provides opportunities for a greater number of jobs, especially for the better-qualified workers. A

[11] Cedefop, Netherlands - VET in Europe – Country report, 2013. For comparison, in 2014 the employed labour force concerned 7.2 million or by around 65,7% (Source: Statistics Netherlands - CPB).

[12] Eurofound, More and better jobs in home-care services, 2013.

large majority of the labour force is female and there is a common opinion that being employed in domestic services is not a serious profession.

The offer is generally insufficient relative to demand, particularly due to the lack of skilled labour, a high turnover, and still too low use of new technologies for the development of new services and for matching supply and demand.

Contractual relation between employer and employee

When older or disabled people hire employees to do household care for a maximum of three days per week, the contract is then subject to the Domestic Work regulation of 2007[13]. Consequently, people hiring employees under these conditions are exempt from any social contributions and taxation, layoff authorisation or administrative obligation. They can use their personal budget (PGB) attributed by the municipality to pay the employee's wage.

Employees must be paid at least in accordance with national minimum wages, be entitled to 8% vacations payment and to four weeks of paid leave. They don't receive benefits of standard labour contracts, such as participation in pension funds, unemployment benefits and insurance for unfitness to work.

As older people were often uninformed of the responsibilities associated with being an employer, the contractual relation fits for people who are able to take on the role of employer.

With regards to service quality delivered at home, the domestic help allowance (HHT) and the condition that it can only be used for regular employees will contribute to the greater employability of employees concerned. Yet municipalities prefer to remain the Alfa construction for domestic services, for instance by the mean of the PGB or through general provisions. This preference creates tensions between the desire to provide as much care as possible and the principles of decent work.

Existence of a collective agreement

Employees of care businesses or of maintenance/housekeeping businesses benefit of a collective agreement for their sector that can offer them more favourable working conditions than the Dutch common law. This is not the case of individuals offering their PHS: they do not have collective agreement[14]. They must agree with the individual who employs them, on their wage and working conditions. Employees are entitled to a wage at least equivalent to the legal minimum gross wage. Private companies can offer their services at a much higher hourly wages because of social security contributions. At present, it is actually more interesting for the

[13] EFSI, 2013, ibid.

[14] Kergueris J., Services à la personne : bilan et prospective, Rapport d'information, Sénat, 2010.

individual to employ a person without declaring him-her. The employee will also find its interest because the wage is higher than the net wage after declaration to the tax authority.

The trade unions FNV and CNV Vakmensen negotiated a collective agreement for the cleaning sector, including private homes, with the employer organisation OSB in 2014[15]. This agreement only covers cleaning personnel who are employed through agencies, though; workers employed directly by private households are not part of the agreement.

Both employees in the home care sector as well as in the child care sector fall within the scope of a collective labour agreement[16].

- The home care sector's collective agreement contains agreements on wages, payment of overtime, working time, holidays and leave schemes, and training and education. The main goal of this agreement was to set a minimum hourly wage for employees who provide cleaning services at home, in order to prevent further dumping of wages for this profession. Finally parties agreed to set this minimum at EUR 10 per hour. Yet, the social partners also realised that municipalities generally establish a rate of remuneration below EUR 10 when defining terms in their call for tender.

- In the child care sector the collective agreement expired on 1st January 2015, and a new one has not been agreed upon due to difficulties in the negotiation process.

Nature of employer

There are no government-owned care providers in the Netherlands. All providers are private: either not-for-profit (the large majority) or for-profit.

Formal contracts define carers' responsibilities and duties as well as the duration of the working time.

With regard to the undeclared work, the percentage of the Dutch population aged between 15-64 years engaged in undeclared work[17] in the years 2007-2011 has varied between 8 and 10% of the GDP[18]. In 2012 its size has amounted 9.1% of the GDP[19], and the proportion remains unchanged.

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[15] EFFAT, Promote industrial relations in the domestic work sector in Europe, final report, 2015.

[16] EEPO, 2015.

[17] The European Commission defines undeclared work as "paid activities that are lawful as regards their nature but not declared to public authorities" (European Commission, 2007).

[18] Statistics Netherlands, CBS, October 2012.

[19] Schneider F., The shadow economy in Europe, 2013.

According to the EEPO, undeclared work in the Netherlands mainly consists of work for private individuals: small jobs, brief periods, and small remuneration. This description could fit the PHS provision, and this is supported by the relatively high estimated share of undeclared work in the Dutch PHS sector: around 28 to 40 % of work in PHS is undeclared. Yet, indications are that this type of work is hardly the equivalent of a regular job, but rather seems to be work via which people earn some pocket money[20].

The main institution combating undeclared work in the Netherlands is the Inspectorate SZW, within the Ministry of Social Affairs and Employment[21]. Since 1 January 2013, a new law came in operation with severe penalties in cases of breach of labour or social security laws: Act on Enforcement of Labour and Social Security Law (WAHS). This law targets to shift more cases from criminal law to administrative law (by use of fines, warnings). On this new legal basis, undeclared work combined with unemployment benefit leads to very high fines, possible reduction and/or repayment of the benefit. Employers who employ illegal immigrants risk fines up to 36.000€ per illegal worker and/or closing down the business. The same fines are applied for the non-respect of the law on minimum wages (WML), of the Foreign Nationals Employment Act (WAV) and of the Allocation of Labour through Intermediaries Act (WAADI). The risk incurred by a temporary employment agency violating the rules for the first time amounts to a 12.000€ fine for every employed person. With the next violation the fine is doubled.

With regard to the informal care, informal caregivers (family and friends) stay the most important providers[22]. In the majority of EU countries, they provide on average 60% of the total care needed[23]. In the Netherlands, this proportion is lower in comparison to the other countries due to its dense networks of available services. Bettio and Plantenga have stated that: "*In the Netherlands, in fact, the family is considered to be the "natural" provider for children, while the state is thought to be the steward for the elderly*"[24]. In 2007 informal caregivers for all persons in need of care amounted 3.5 million; yet only about a half of them helped others during relatively long and intensive periods[25]. There are no benefits for informal caregivers, but personal budgets can be used for this purpose[26]. Indeed, the personal budget can be used to purchase both

[20] EEPO, 2015.

[21] Renooy P., Labour inspection strategies for combating undeclared work in Europe: the Netherlands, REGIOPLAN, 2013.

[22] EU Expert Group on Gender and Employment (EGGE), Long-Term Care for the elderly. Provisions and providers in 33 European countries, Fondazione G. Brodolini, EU, 2010.

[23] European Observatory on Health Systems and Policies, Home care across Europe: current structure and future challenges, WHO, 2012.

[24] Mot E., 2010, ibid.

[25] Mot E., 2010, ibid.

[26] ENEPRI, Informal care provision in Europe: Regulation and profile of providers, Research report n°96, 2011.

professional care and informal care[27]. According to the law Wmo, local councils are mandated to support informal caregivers, either by organising direct support (advice), or by financing organisations that support them. Furthermore, day care and night care can be funded by the law AWBZ.

Migrant work

Migrant care workers are generally considered as foreign-born people, first-generation immigrants. They are often poorly paid and subject to undeclared work, social security premiums and taxes evasions.

So far, the Netherlands has been the case of exception in Europe: presence of migrant care work within both organisations and households is limited. However, the recent emergence of a market for migrant live-in care workers[28] is the phenomenon increasingly considered as a possible future development of migrant care work[29].

Within the new inspectorate SZW, the Labour Market Fraud Department has a specific role in this regard. It is responsible for supervision of the Dutch legislation, notably of the Foreign Nationals Employment Act (WAV) forbidding employers and persons to hire migrants without a valid work permit.

Trade unions play an important role, too. They act as a partner of the government in preventing and combating undeclared work and in promoting decent wages and working conditions for migrant workers, in accordance with the signed collective agreements and the WAGA. Dutch trade unions are also actively supporting the struggle of domestic workers for decent working conditions (Abvakabo and FNV Bondgenoten).

Employers' associations also play an active role in this respect, especially in the temporary employment agency sector. Collective agreements, notably on wages and other working conditions, count among major instruments in preventing and combating undeclared work and in promoting decent wages and working conditions for migrant workers[30].

2.1.2. Income and social protection

The Minimum Wage and Minimum Holiday Allowance Act (WML) requires payment of a

[27] ENEPRI, 2010.

[28] Centre of expertise for informal care, Live-in migrant care workers in the Netherlands: an exploration of the field, 2014.

[29] Da Roit B., van Bochove M., Migrant workers in long-term care in the Netherlands from a comparative perspective: a literature review, Centre of expertise for Informal Care, 2014.

[30] Regioplan, Labour inspection strategies for combatting undeclared work in Europe: the Netherlands, 2013.

minimum legal wage and of a minimum holiday allowance to every legally hired person. The law does not specify the number of working hours in a week. The usual working week consists of 36, 38 or 40 hours. In 2015, based on 40 working hours per week, the minimum wage has amounted 1.501,80€ per month, 346,55€ per week, 69,31€ per day, 8,66€ an hour[31]. The minimum wage is lower if the worker is under the age of 23. A tax is included in these wages - approximately 30% of the wage - so the worker receives about 2/3 of the given wages[32].

With regard to median wages, in 2013 the monthly gross median wage amounted 3540,90€[33]. The amount covers total wages and salaries in cash and in kind, before any tax deduction and before social security contributions. Median wages include wages and salaries, remuneration for time not worked, bonuses and gratuities paid by the employer to the employee. In most countries wages are expressed in full-time equivalent worker, in order to enable transnational comparison independently of the number of working hours and of the share part-time / full-time workers. As concerns the PHS sector, the wages amount from EUR 2.200 to EUR 2.600[34].

In terms of the social protection, the Dutch law subordinates every inhabitant to social insurance. Also those who work and pay income tax are insured. Employed persons have employee insurance by law (unemployment benefit, disability benefit).

Additionally to social insurances, the Netherlands complements insufficient family incomes up to the social minimum in some living circumstances: the Supplementary Benefits Act (TW), the Disablement Assistance for Disabled Young Persons Act (Wajong), the Income Provisions for Older or Partially Disabled Unemployed Persons Act (IOAW), the Income Provisions for Older or Partially Disabled Formerly Self-Employed Persons act (IOAZ), the Investment in Sustainable Work for Young People Act (WIJ), the Supplementary Old Age Pension (AIO) and the Artists Work and Income scheme Act (WWIK)[35]. The long-term unemployed are subject to the Employment and Social Assistance Act (WWB).

2.1.3. Workers' rights

Rights to collective bargaining

The Social and Economic Council of the Netherlands (SER) specifies that the Collective

[31] Government of the Netherlands, http://www.government.nl/

[32] Wage Indicator, Netherlands 2015, http://www.wageindicator.org/main/salary/minimum-wage/netherland.

[33] Source: UNECE.

[34] http://www.wageindicator.org/main

[35] Regioplan, 2013, ibid.

Agreements Act[36] (the AVV Act) "*allows government to extend the scope of the collective agreement arrangements within a sector to cover companies that are not affiliated to an employers' association that is a party to the collective agreement concerned. The collective agreement can then apply, in principle, to the whole of the sector."*[37]

The AVV Act states that the Minister of Social Affairs and Employment is allowed to declare collective agreement provisions agreed in a sector between employers and employees, provided that the Minister considers the rules essential for the majority of persons employed in the concerned sector[38]. This is illustrated by the collective labour agreement for temporary agency workers, which was negotiated and agreed for the 2012-2017 period.

Regulations on "services in the home" (*Regeling Dienstverlening aan huis*) contain provisions excluding employers from the duty to pay social security contributions and taxes if the domestic worker is employed for only 3 days a week or less. It is the worker's responsibility to pay social security and declare taxes (domestic workers are not automatically included in the social security system)[39].

The regulations also provide for a maximum of 6 weeks of sick leave whereas the norm in the Netherlands is 2 years. These rules effectively foster informal employment relationships, where work remains undeclared and even the minimum labour rights of the domestic workers are not respected.

Representation of domestic workers

Paid domestic work in the Netherlands predominantly takes place informally, as it has traditionally not been considered a sector for full-time employment. As such it is one of the few areas in which (especially undocumented) migrant workers find employment.

The trade union FNV has recognised these workers as a relevant workforce and is offering membership regardless of legal residency status. The undocumented migrant domestic workers, who belong to different migrant domestic worker groups (self-help groups, some of them describing themselves as unions, but without being affiliated to official Dutch union structures) are now organised within the cleaning branch of FNV. One of these groups is the Indonesian Migrant Workers Union, which counts approximately 400 members. Other groups include the United Migrant Domestic Workers (UMDW), Otradela, Filipino Migrants in Solidarity (FILMIS), as well as Indian and Ghanaian groups. Some of these groups are also members of

[36] In Dutch: Wet op het algemeen verbindend en het onverbindend verklaren van bepalingen van collectieve arbeidsovereenkomsten

[37] Sociaal-Economische Raad (SER), Universal applicability of collective agreements, www.ser.nl

[38] Regioplan, 2013, ibid.

[39] EFFAT, 2015.

the RESPECT Network Netherlands, which represents undocumented migrant domestic workers.

The different domestic worker groups are represented within the “cleaners’ committee” of FNV and have formed a domestic workers “organising committee”. They run a campaign for the ratification of ILO Convention 189 by the Dutch Government, which would entail a reform of the domestic work sector in the Netherlands to allow domestic workers the same rights as other workers.

2.2. Skills development and professionalisation

The community-based care in the Netherlands is a sector with increasing demands for quality and skills.

The skills that will be relevant for the future are influenced by several phenomena, especially: shifting care from institutions to people’s homes, the use of new technologies and the use of different diagnostic techniques.

The new health professional works in various care areas and in varying settings, and he-she works as a generalist. The most important skill is to “deescalate”: professional attention is always focused on functioning of citizens in their own environment as independently as possible. Thus after treatment, surgery or temporary takeover of function the concern is focused on return of citizens to their own home or environment.

Regarding the qualifications of care and domestic workers, the Netherlands has educational requirements for nurses. Their training takes three to four years. Nurses require continuous recertification that involves additional training or passing a test every few years. Specialisation (or postgraduate education) is possible for nurse specialists.

With regard to training, here is no national training or upgrading policy for personal household services in general. However, there are few local development initiatives in the supply of personal services. For instance, in Tilburg, people over 55 years old may use the home care service area "WoonZorgService in Wijk" (WZSW[40] using "service vouchers"). This initiative combines assistance to seniors with a tool for reintegration of the unemployed into the labour market. After training, the latter can establish themselves as self-employed in the sector of personal household services. For this type of local initiative, municipalities are free to use the financial resources of benefits (social and unemployment) they have. The Ministry of Labour and Social Affairs has shown interest in developing these initiatives by commercial enterprises at the national level.

[40] Woonzorgservice in de wijk (WZSW), http://www.wzsw.nl

The Netherlands faces staff shortages within the home care services sector. In the long term, increasing shortages are to be expected, especially for better-qualified workers.

According to Eurofound, at the moment, the shortages in community-based health care are relatively small (mainly at qualification level 3 (intermediate vocational level) and for some specific professions), but in the coming years these shortages probably will increase, particularly at the higher-qualification levels. Due to the cost-reduction policies of the government, there is and will be a labour surplus in welfare-related social care work, while there is a shortage of labour in healthcare. The qualifications, skills and competences that employers demand from home-care workers are increasing, concludes Eurofound, mainly as result of the expanding coordinating role they have to play[41].

Furthermore, high unemployment rates are making the sector more attractive to work in, while the increasing emphasis on labour market measures may succeed in boosting recruitment.

In this regard, it is worth to mention the Dutch innovative strategy to recruit and retain employees: *the use of telecare*. Video networks enable home-care clients and home-care providers to contact each other by use of a camera and a screen. A home-care provider can be contacted at any time, day or night. This was expected to heighten clients' sense of safety and independence and intended to substitute in part for home visits by home-care providers[42].

2.3. Health and well-being

The Inspectorate SZW works for fair, healthy and safe working conditions and socio-economic security for everyone[43].

Studies show there are reasons to consider work in the Dutch private care sector as precarious work. Private domestic work remains often undeclared[44]. For instance[45], for household services anyone outsourcing any form of work in the home for three days a week or less is exempt from paying social premiums and deducting taxes and from dismissal permit requirement. Furthermore, the number of (undocumented) migrants on (growing) market for undeclared work is increasing.

With regard to the work/life balance, the Inspectorate SZW states that "the Working hours Act (*Arbeidstijdenwet*) and the Working Hours Decree (*Arbeidstijdenbesluit*) are the hours that

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[41] Eurofound, More and better jobs in home-care services: the Netherlands, 2013.

[42] European Observatory on Health Systems and Policies, 2012, ibid.

[43] Inspectorate SZW, http://www.inspectieszw.nl/

[44] European monitoring centre on change (EMCC), Regulation of domestic work, Netherlands, 2009.

[45] Van Walsum S., The (Non)regulation of Domestic Work in the Netherlands, International seminar "Regulating decent work for domestic workers", 29 March 2010.

employees are permitted to work within a given period of time and when they have the right to take a break or period of rest. Besides this, there are exceptions in working hours in the care sector."[46]

3. SERVICE QUALITY

3.1. Availability and affordability of services

In terms of availability of services, geographically, the Netherlands offers a dense network of home care.

The Dutch potential users have a choice between two options: allowance systems for home care under which people are eligible for benefits in kind, or cash benefits (also called personal-care budget). Thanks to benefits in service or personal budgets, the Dutch people can choose the providers and even the type of care, unless there is a shortage or even absence of providers. Clients also have the opportunity to influence the quality of care, as they are given the chance to complain.

The European Observatory on Health Systems and Policies points out many initiatives launched in order to raise clients' awareness on the home-care services availability. For instance, special info centres in municipalities and a national-level website were set up to inform people where and how they can apply for care[47].

It is worth mentioning that the LOC Voice in Healthcare[48] represent the interests of an important number of people in need of care. This organisation gives the say and participation in healthcare as well as in general life to about 600.000 clients.

In terms of affordability of services, the principle of universal access to services for people in need of care and assistance is stated by AGE Platform: they should be provided either free of charge or at a price which is affordable to the individual without undue compromise to their quality of life, dignity and freedom of choice[49].

Observing the present situation in the Netherlands, the country has one of the largest EU-member states shares of people served by home care: the utilisation rate reaches 4.8% of the

[46] SZW, http://www.inspectieszw.nl/english/working_hours/

[47] European Observatory on Health Systems and Policies, 2012, ibid.

[48] LOC Voice in Healthcare, www.loc.nl

[49] AGE Platform Europe, 2010-2012, ibid.

total population[50]. When considering only people over the age of 65 in the EU, the Netherlands covers one of the largest shares. These indicators show the relative "generosity" of the country in terms of home-care provision.

Care users' eligibility for care is assessed by an independent Care Assessment Centre CIZ[51], except for home help where the assessment lies with municipalities. The CIZ determines the nature of users' eligibility: care in an institution or at home, as well as the quantity of care they are entitled to. Once evaluated, users can choose between in-kind care and a cash benefit (personal budget) that is equivalent to 75% of the cost of in-kind care. Cash benefits represent 11% of total expenditure[52].

Since co-payments for the AWBZ are income-dependent, care users are not supposed to encounter severe financial difficulties[53].

In order to defend fair competition, the country has created the Healthcare Authority (NZa). This organisation ensures the positive effects of competition through the prevention of monopolies or abuse of market power by providers or insurers.

3.2. Comprehensiveness of services

As stated by AGE Platform, services for people in need of care and assistance "should be designed and delivered in an integrated manner which reflects the multiple needs, capacities and preferences of the older person and, when appropriate, their families and carers, and which aims to improve their wellbeing."[54]. But even more important, services for people in need of need of care and assistance should be easy to access by all those who may require them. A strategy is now in place to systematically communicate information about the quality of available services and providers to service users and informal carers[55]. Transparent comparison aims at helping the service user to make informed choices for care, as well as stimulating care providers to provide quality care. Organisations are required by the National Healthcare Authority to compile their data on quality and on efficiency and make reports available.

Transparency is one major aspect, but comprehensiveness of services also includes how far the government supports a varied range of services and the development of integrated services (health and social), with comprehensive assessment of needs and adaptation to the needs (for

[50] European Observatory on Health Systems and Policies, 2012, ibid.

[51] Het Centrum indicatiestelling zorg (CIZ), www.ciz.nl

[52] OECD Economic surveys: Netherlands 2012.

[53] The AWBZ is funded by social security premiums, taxes and co-payments (Mot Esther, 2010, *ibid*).

[54] AGE Platform, WeDo quality principles, 2010-2012, ibid.

[55] INTERLINKS, Quality management and quality assurance in LTC, European project INTERLINKS, 2010.

a person centred care). The Dutch government does not provide this kind of support, but the support is increasingly being provided by municipalities. For instance, Eindhoven uses the system with "ranking stars"[56].

3.3. Quality of regulation

Two accreditation bodies have been set up by the Dutch health care field: one for accreditation of hospitals (NIAZ) and the other for harmonisation of quality reviews in health care and social services (HKZ). The latter produces certification schemes and is an initiative of care providers, insurers and clients.

With regard to the inspections, in case of HKZ certification an external organisation assesses if the quality management of the organization meets predetermined HKZ standards. An institution designated by the Accreditation Council (RvA) executes it. The assessment is subject to strict rules. If the organisation meets the standards, it shall issue a Certificate HKZ. The certificate is valid for three years, subject to a mid-retest. A recertification takes place after three years.

Labour inspectorates have a general mandate to ensure compliance with laws and regulations in the domestic work sector.

3.4. Quality of management and organisational level

For the quality assessment of home care, the country has the Health Care Inspectorate (IGZ)[57] that holds responsibility for the quality of services supervision. Home care agencies are legally committed to thoroughly monitor and improve the quality of their services and staff working conditions and to provide annual reports to the IGZ. The Inspectorate can also do audits.

Furthermore, service providers, professionals and service users mutually agreed to use common indicators which compose the Dutch Quality Framework for Responsible Care (QFRC). It contains measurable indicators that show if the organisation provides quality and responsible care. QFRC is important if one pretends to become member of the Dutch Organisation of Care providers (ACTiZ)[58].

At present, most services in LTC for older people take part in a national benchmark. Interlinks indicates[59] that is covers issues such as staff (quality of work), financial performance, clients indicators (Responsible Care Standards), services delivery, satisfaction of employees and

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[56] http://eindhoven.werksite.nl/loopbaanbegeleiding

[57] De Inspectie voor de Gezondheidszorg (IGZ), www.igz.nl

[58] ACTiZ, www.actiz.nl

[59] INTERLINKS, 2010, ibid.

quality outcomes. Some methodological questions remain however to be answered, notably the difficulty to operationalise quality. The improvements to be made are under the responsibility of the organisation concerned.

It should also be noted that evaluation of client satisfaction with the service quality is increasing. Client satisfaction surveys for measuring quality have become mandatory.

Since 1st January 2015 many institutions anticipate cutbacks and changes in regulation. Especially in the domestic help are many layoffs. And elsewhere jobs will disappear. Several providers now indicate that the flexible workforce within their organizations is now disappearing. Employees with temporary contracts have been made redundant, trainees are not employed, and management layers are gone. New layoffs will hit the hard core of professionals, starting with the new influx, including many young people.

At the same, the aims of the new WMO demands a modernization process, requires flow of jobs and needs creating new jobs (especially within the new 'social teams' that municipalities organize to perform their new tasks) with other competencies. From this perspective, we have a short-term quantitative problem, but in the long term there is a qualitative statement.

4. CONCLUSION

A tendency towards decentralisation of responsibilities of the PHS can be observed in the Netherlands, partly for budgetary reasons, but also in order to better meet local particularities[60]. Eurofound actually notes that the Dutch policy focused on increasing the level of home care as well as moving the responsibility from the state to the local level. At the same time, the country puts efforts in reducing the demand for care by, for instance, focusing on prevention, self-management and informal care[61].

The decentralisation tendency has significantly increased since 1St January 2015, with the implementation of the new WLZ and the Wmo 2015. The new tasks and responsibilities of municipalities have been decentralised with great budget cuts; for instance, for personal care at home the budget amounts 40%![62] It is expected that a lot of these tasks will be taken over by the informal network, as well as cheaper contract with care providing organisations. Yet, bearing in mind that the new legislation has only been implemented recently, its meaning and impact still needs to be established[63].

The Dutch government supports the sector in 2015 and 2016, notably throughout the domestic help allowance (HHT). The consequences of budget reductions on light domestic help are that employment disappears or shifts from the public to the private sector.

But these changes are also a fertile terrain for innovation[64]. Although this is the premise of the HHT, in practice, the fee is still mainly used by municipalities as an instrument to preserve jobs. That does not help to achieve the aims of the new legal framework.

At present a focus should be placed on renewal and sustainable solutions, particularly in the domestic services at home. That creates new jobs for wide support activities, regardless of care. Innovative entrepreneurs are ready, but the guidance is needed towards a new market, to prevent employees redundant while they are desperately needed later.

The quality of services delivered at home may be improved by investing in the following skills:

- Promoting independently functioning/operating (rather than treating)

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[60] INTERLINKS, 2010, ibid.

[61] EUROFOUND, 2013.

[62] Verbiessen J., “One family-One plan” scheme - Municipality of Heusden, Practices on workforce development & service quality, European project For quality!, Second regional seminar, Brighton, 27 May 2015.

[63] EEPO, 2015.

[64] Conclusions and recommendations from: Broumels Joost, Rapporteur of the Group discussion Netherlands, For quality! European project, Second regional seminar, Brighton, 27 May 2015.

- De-escalating: professional activities are to be focused on people operating independently or as independently as possible in their own environment
- The use and application of new technologies: eHealth, home technology and robotics
- Networking skills, social skills and knowledge of the context in which performance problems occur. Especially in the context tend to find solutions that are now hardly used (education, housing, security, sport- facilities, and infrastructure).

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