Employment and social dialogue in welfare services in the Netherlands

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Introduction

Characteristics of the labour market in the Netherlands are in a nutshell: high employment rates, low unemployment, fast increasing levels of education, fast demographical ageing in the workforce, and high persistent gender inequality in employment participation and (many small) part-time jobs among women. The Dutch 'part-time economy' is extremely visible in the care sectors.

The sector of 'Health and social work' is the sector with the highest growth of employment in the last two decades in the Netherlands. Together with the sector of trade, it is nowadays the sector with the highest number of workers (1.5 million). The vast majority of the care-workers are female, and therefore part-time jobs are widespread in the care sectors, with an average of just 24 hours a week. Since 2011, the category of 'Professionals' has become the largest occupational group, and educational levels have increased in the care sectors.

This report focuses on two care sectors: the childcare sector and the long-term care sector. The childcare sector (ECEC) is a private and commercial sector in the Netherlands, subsidized by public money (for disadvantaged families and through co-financing parents' contributions) and regulated by statutory quality frameworks. The sector's governance, funding, and provision of services are very fragmented (chapter 2). In the case of ECEC in the Netherlands, we see more clearly the negative effects of privatization since 2005 in the labour market and quality of work in the sector. Childcare centers face a qualitative mismatch in the labour market: they need more educators, but there is a lack of career and training opportunities in the sector for these workers. ECEC employers also have a bad public image due to low job security, low wages and social unrest in the sector (chapter 3, 4). The organisation of employers and collective bargaining in the ECEC sector are fragmentised and 'yellow unions' have penetrated the sector.

The long-term care sector (LTC) is a not-for profit sector, increasingly governed by principles of cost control and efficiency. Since 2007, homecare provision is regulated by instruments of public procurement at the level of municipalities. In 2015, a broader LTC-reform pushed further to decentralisation to municipalities, individual responsibility, more focus on non-residential care, and expenditure cuts (chapter 2). Since 2019, the government seems to have become more aware of the longer-standing disappointing performance of the earlier introduced market mechanisms in the Social Support Act with regard to the quality of services as well as the quality of jobs and working conditions in the homecare sector. Nevertheless, this system is not structurally changed. In the recent years the relations between the social partners in the LTC sectors have recovered from an impasse, leading to some improvements in collective agreements regarding wages and regulating working hours flexibility in the sector of nursing homes and homecare. Social partners in LTC cooperate together in combatting low wages, high workloads and labour scarcity.

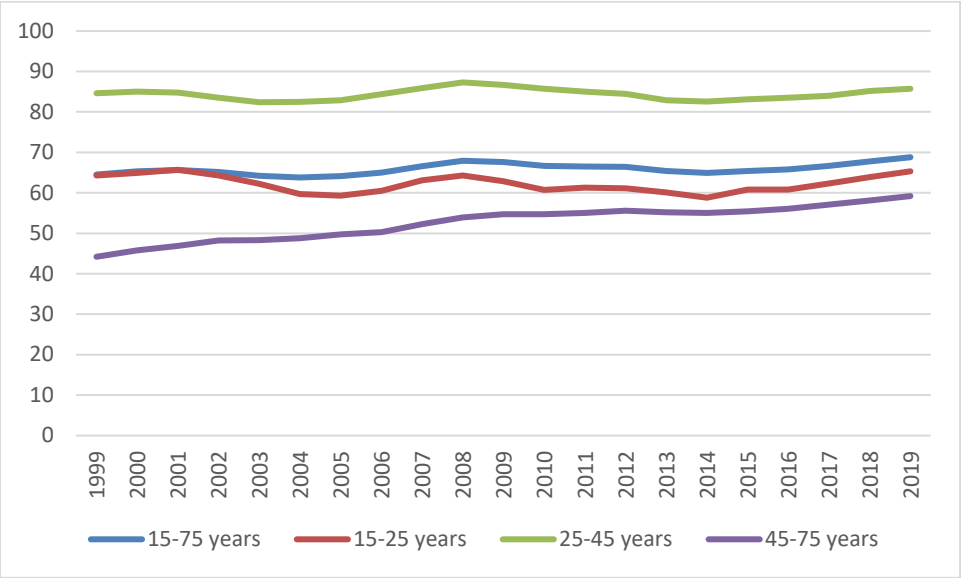
1. Labour market and employment in the Netherlands and its care sectors

1.1 National characteristics and trends

Employment rates and inequality in age and gender

Labour participation in the Netherlands is high: 80.1 percent of the workforce till 65 years is in employment in 2019. The employment rate in 2019 is 6.2 percent point higher than the EU average (SOWELL, 2021: 19, 63). The participation in age group 25-45 years is at a very high level: 85.7% in 2019. Especially in the age groups of 25-34 years, employment rates in the Netherlands are high (SOWELL, 2021, 19, 63). Participation of those aged above 45 years is substantially lower in the Netherlands as we can clearly see in figure 1.1. But employment rates are also among older workers still higher than average in the EU, especially in the age group 60-64 years (61% in NL and 46% in EU). Participation in the age-group 45-74 years increased substantially in the last two decades in the Netherlands: from 46 percent in 2000 to 59 percent in 2019. This is mainly the effect of institutional reforms regarding the dismantling of early retirement arrangements and the pension-reform towards higher statutory pensionable ages. Because of demographical ageing in the whole population, the group of older people in the labour market has grown even more. Figure 1.1 shows also some effects of the Great Recession: in 2009-2014 labour participation deceased among the youth and among the middle-aged workers.

Figure 1.1. Labour participation by age groups, 1999-2019 (net in percentages)

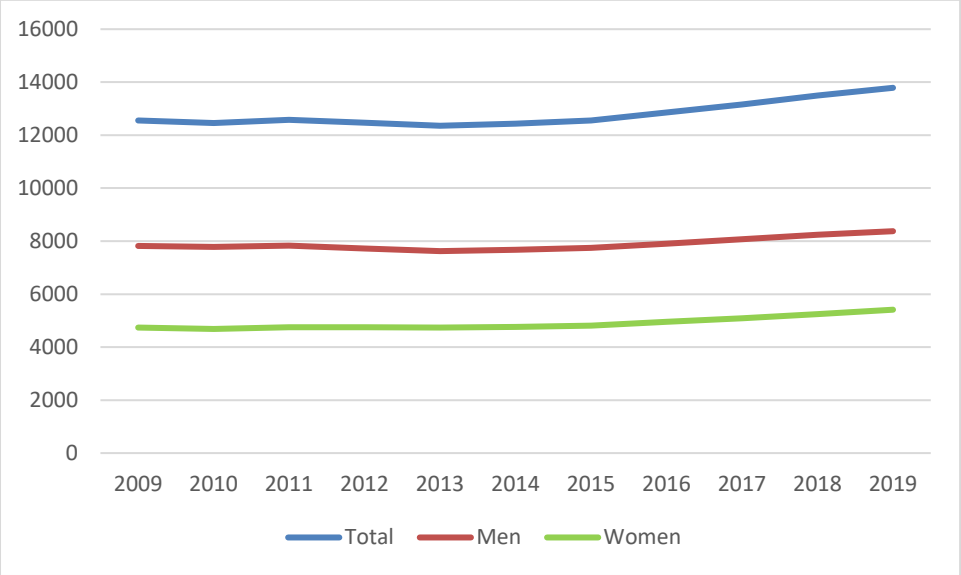


Source: CBS, Statline

There are persistent gender-differences in the labour market in the Netherlands. 73.4 percent of the men and 64.4 of the women in the age-category of 15-74 years has paid

work. Looking at the number of worked hours, the gender differences are even bigger. In 2019, women in the Netherlands worked 39 percent of the total real hours worked, and men 61 percent (see figure 1.2). Also in this figure we see some moderate effects of the Great Crisis: only after 2014 did the total number of worked hours in the Netherlands grow again.

Figure 1.2. Number of real hours worked, by gender, 2009-2019 (x million)

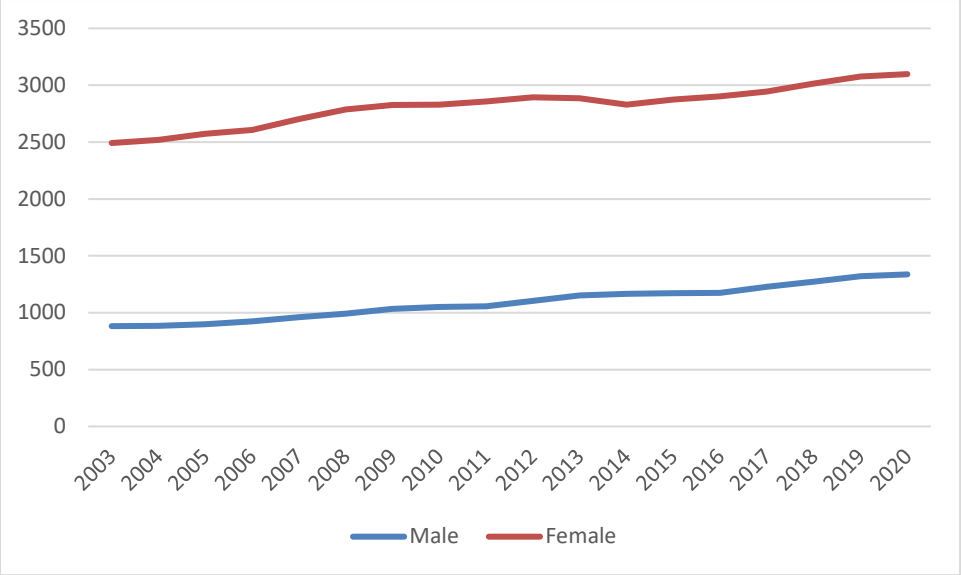


Source: CBS, Statline

The Netherlands is a 'part-time economy'. In 2000, 50 percent of the workers worked full-time and 50 percent worked part-time. The numbers of part-time workers increased further during the last decades. In 2020, more than 3 million women worked in part-time jobs, compared to 1.3 million men. There is no evidence of a trend towards less gender inequality in this subject in the last 20 years (see figure 1.3). Relatively high shares of part-timers have chosen voluntary for part-time jobs.[1] In 2020, around 389,000 part-timers want to work more hours and is also available for this.

Figure 1.3. Number of part-time workers by gender, 2003-2020 (x 1000)

[1] Although in a broader societal frame, the distribution of household tasks are unequally distributed between men and women and access to childcare is limited, what is limiting the actual options for women to work full time in paid jobs.

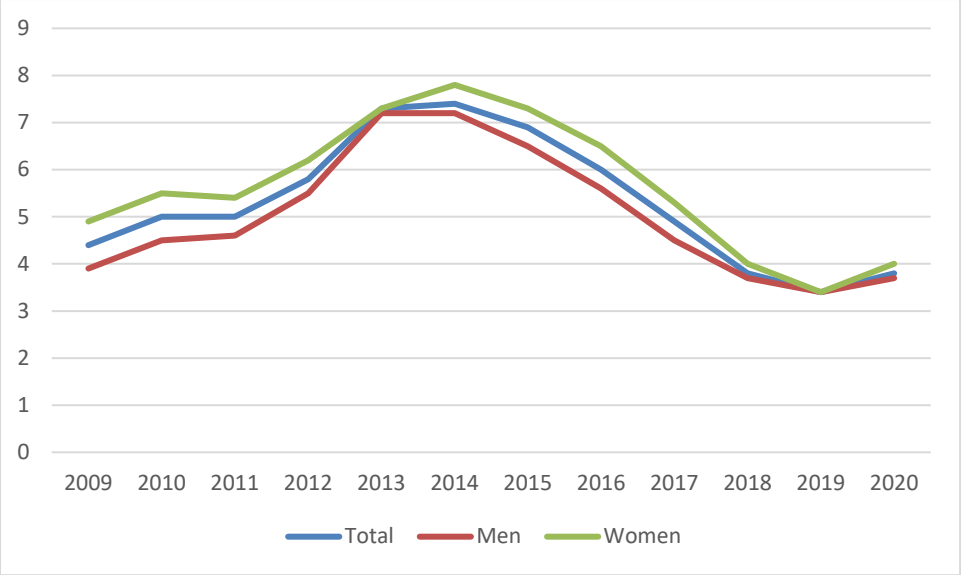


Source: CBS, Statline

Unemployment

Compared to other European countries, unemployment is low in the Netherlands. In 2019, unemployment was 3.4 percent in the Netherlands and 6.4 percent in the EU. Nevertheless, also in the Netherlands unemployment has grown in the years after the Great Crisis. From 4.4 percent in 2009 to 7.2 percent in 2014. The gender-differences vary a bit from year to year and national statistics differ slightly from European statistics. According to national statistics, unemployment among women has never been lower than unemployment among men (figure 1.4). While this has been the case in Europe as a whole since 2012, according to Eurostat data (SOWELL, 2021: 63).

Figure 1.4. Unemployment by gender, 2009-2019 (in percentages)

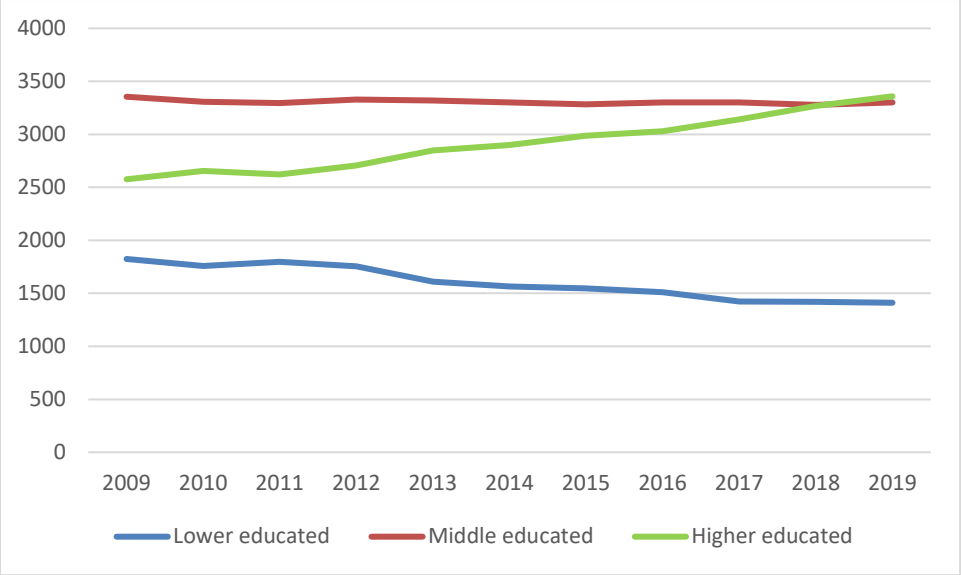


Source: CBS, Statline

Education levels and occupations

Figure 1.5 shows clear trends in the composition of the workforce in terms of education levels in the Netherlands. Since 2018, medium educated workers are no longer the largest group in the Dutch labour market, since the number of higher educated workers has grown quite fast and is now equal to the number of medium educated workers. In the EU as a whole, the share of higher educated workers has also grown (till 36%), but remains below the size of the group of medium educated workers (47%) (SOWELL, 2021: 20). Furthermore, the number of lower educated people in the Netherlands has decreased from around 1.8 million in 2009 to around 1.4 million in 2019.

Figure 1.5. Workforce by educational attainments in the Netherlands, 1999-2019 (x1000)



Source: CBS, Statline

Looking at shares of occupation categories in the Dutch labour market compared to the whole European Union, we see one main difference. In the Netherlands we see a higher share of 'professionals'[2], namely 27%, compared to 20% in EU (SOWELL 2021: 15, 60). This difference with the EU is even bigger among female workers: 33% in NL versus 23% in EU are professionals (SOWELL, 2021: 18, 62).

Since 2008, we see two main developments with regard to occupation categories in the Netherland. Firstly, a huge increase in numbers of 'professionals' by 54 percent in the period 2008-2019, the same growth rate as in other European countries (SOWELL 2021: 14, 59).[3] Secondly, a huge decline in the group of 'managers' by 46 percent in the same period, at the same rate among male and female workers.[4] This decline of managers in the Netherlands is twice as big as the European average. Furthermore, we see a stabilization of skilled jobs for male workers in agriculture, while this sector is shrinking substantially in Europe, and moderate-high growth of service and sales-workers (incl. personal care), equal to the European average (SOWELL 2021: 14, 59: 18%, 17%).

[2] 'Professionals' increase the existing stock of knowledge; apply scientific or artistic concepts and theories; teach about the foregoing in a systematic manner; or engage in any combination of these activities**.** Occupations in this major group include health professionals (those that conduct research; improve or develop concepts, theories and operational methods; and apply scientific knowledge relating to medicine, nursing, dentistry, veterinary medicine, pharmacy, and promotion of health).

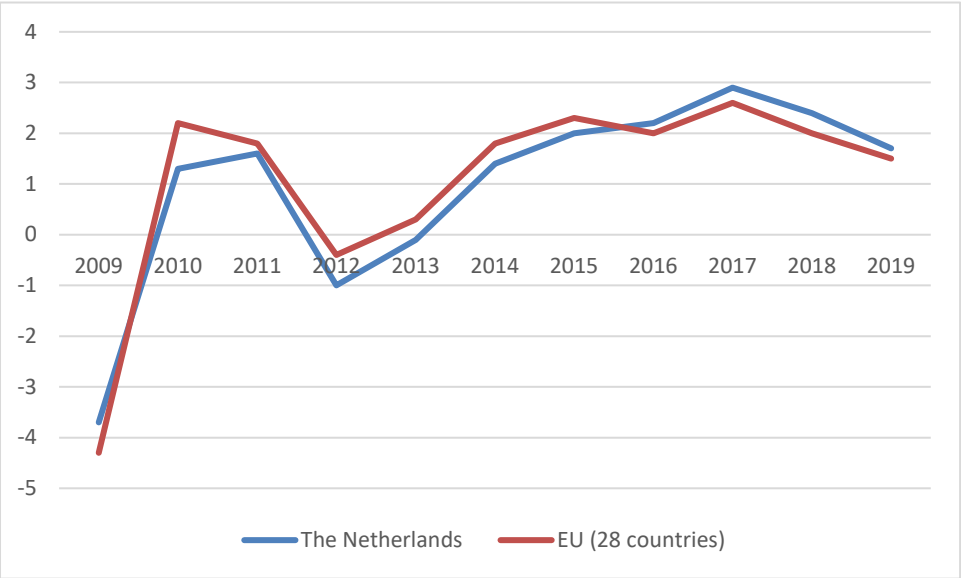
[3] Even higher growth within the female workforce in the Netherlands: 59%.

[4] 'Managers' plan, direct, coordinate and evaluate the overall activities of enterprises, governments and other organisations, or of organisational units within them, and formulate and review their policies, laws, rules and regulations.

GDP growth and share of public employment

Figure 1.6 shows (almost) the same trends in GDP-growth in the Netherlands and in the EU as a whole in the period 2009-2019. Nevertheless, the second decline after the Great Recession started one year later than in the EU, in 2011. Since 2016, GDP in the Netherlands has grown slightly more than the EU average.

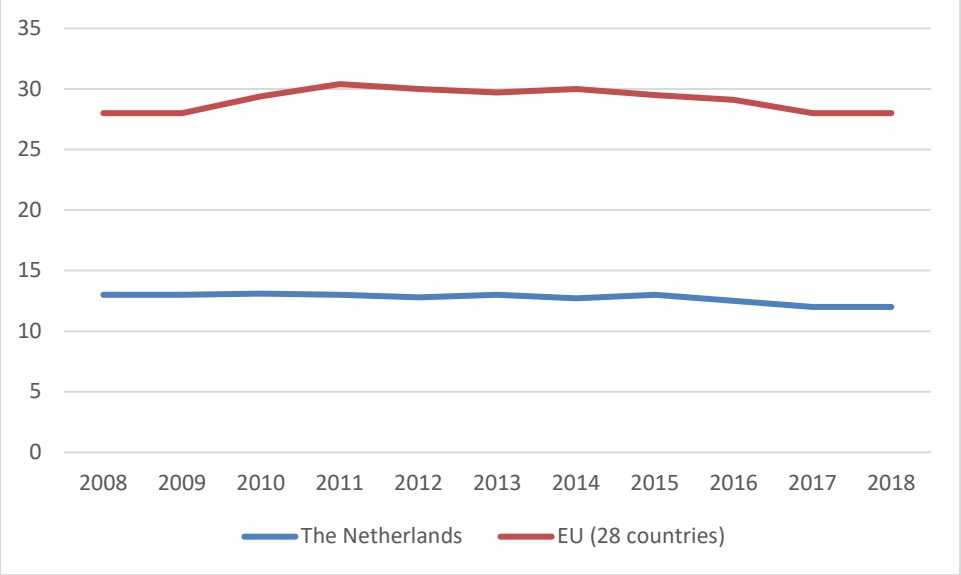
Figure 1.6. Yearly GDP growth rates 2009-2019, The Netherlands and EU



Source SOWELL, 2021/OECD

Figure 1.7 shows clearly lower shares of public employment in the Netherlands. It even decreased from 15 percent in 2008 to less than 12 percent in 2019. The Dutch public sector includes public administration at national, provincial and municipality levels, judiciary, district water authorities, education, security forces and police, and university hospitals. In addition, not-for-profit organisations engaged in, for example, health, welfare/social work activities and public housing provide public services and are co-financed by public money, but are private organisations and their employees are not civil servants. They are also called 'semi-public' organisations in the Dutch context, i.e. private organisations with a public goal.

Figure 1.7. Shares of public employment 2008-2019, The Netherlands and EU



Source SOWELL, 2021/OECD

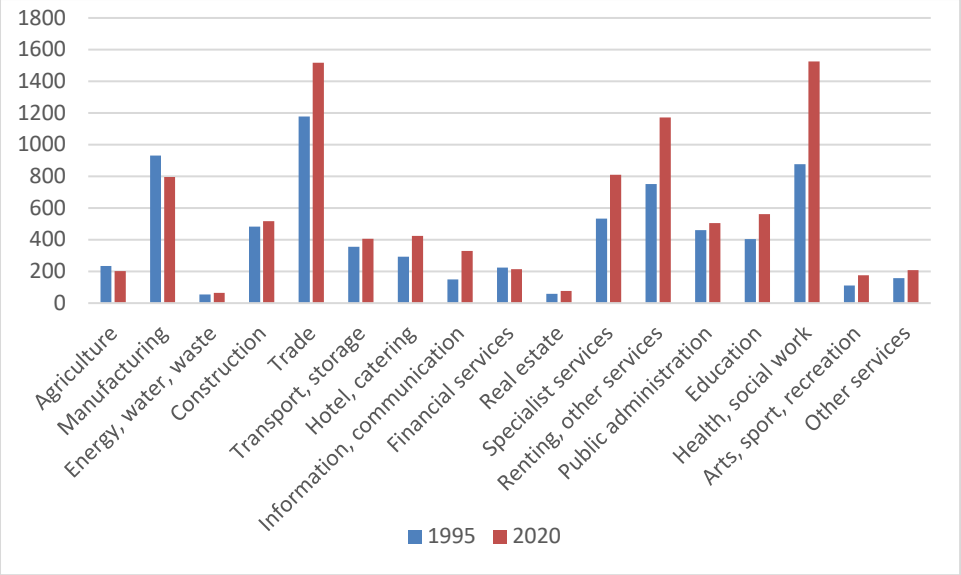
In sum, the Dutch labour market shows high employment rates, low unemployment, increased levels of education and increased numbers of older workers active in the labour market. But also very high numbers of women who work part-time and, as we will see later, a low performance with regard to the quality of work in lower segments of the labour market, including insecurity for workers in flexible, temporary employment.

1.2 Labour market and employment in the care sectors in the Netherlands

1.2.1 Health and social work activities

We see divergent developments in the numbers of workers in the economic sectors in the Netherlands. Figure 1.8 shows the numbers of both employees and solo-self-employed workers in the years 1995 and 2020. Nowadays, the two largest sectors in terms of number of workers are Trade and Health/social work activities. The last mentioned sector grew the most: from 876,000 workers in 1995 to more than 1.5 million workers in 2020! Other sectors grew slower or shrunk, such as Agriculture and Manufacturing.

Figure 1.8. Number of workers by sector in the Netherlands, 1995-2020 (x1000)

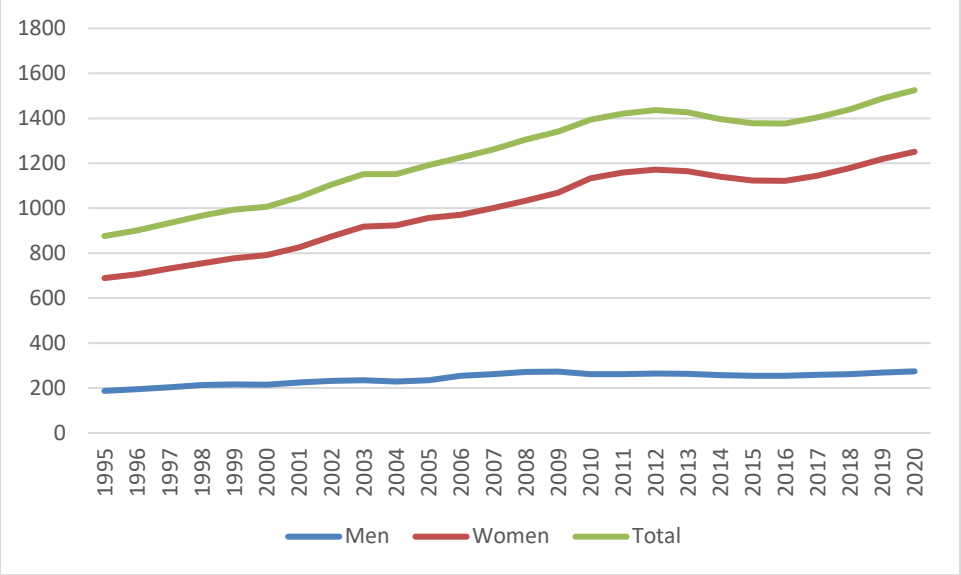


In 2020, 1,525,000 people worked in the sector of Health and social work. The vast majority of the workers in this sector are female: 1,251,000, 82 percent (compared to 78% in the EU). Figure 1.9 shows that the growth of employment in this sector mainly concerned women. In line with female workers in other sectors, the vast majority of women in this sector work part-time. The average care professional works around 24 hours a week and more than half of the labour contracts in the sector regulate a maximum of 25 hours a week. In a recent agreement between the Ministry of Health, Welfare and Sports and employers' associations, municipalities and other stakeholders (but without trade unions involved in collective bargaining), it was agreed that the proportion of the workforce employed in the health en care sectors should not increase beyond the current level; 1/6th of the working population is now employed in the sector (Integraal Zorg Akkoord, 2022).

There are many unfilled vacancies in the care sectors and expectations are that there will be even more vacancies in the coming years (CBS, Eurofound 2020a:16; SER, 2021, interviews).[5] The Covid-19 crisis has a further upwards impact. In the context of longer-standing labour shortages, it can be called remarkable that the numbers of non-nationals working in the care sectors in the Netherlands even decreased between 2010 and 2017 (Eurofound, 2020a: 12).

Figure 1.9. Number of workers in the Health and social works activities, 1995-2000, by gender (x1000)

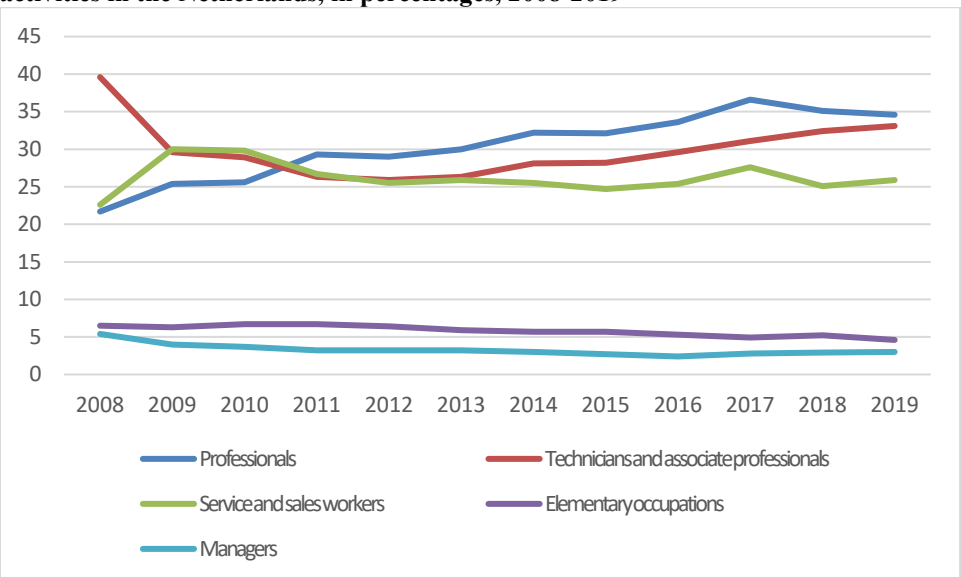
[5] In the sector of Health and social work activities 45,000 in the 2nd quartile of 2021.



Source: CBS, statline

Figure 1.10 shows the labour market composition in the 5 most common occupation categories in the sector of Health and social work activities since 2008 in the Netherlands. The share of professionals has increased from 22 to 35 percent and is nowadays the largest occupational group (quite similar to the development and situation in the whole EU, SOWELL 2021: 125). Since 2011, the group of technicians and associate professionals is no longer the largest in the sector, although still at a higher level than the average in Europe (33% in NL and 23% in EU). The number of service workers remained quite high at a level of around 25 percent (not very different from the EU level). The share of managers decreased from 5 to just 3 percent in 2019, as had already happened in the EU as a whole. The share of elementary occupations is nowadays less than 5 percent, compared to 7 percent in the EU as a whole (SOWELL, 2021: 125).

Figure 1.10. Labour market composition by occupational categories in sector of health and social work activities in the Netherlands, in percentages, 2008-2019



Source: Eurostat, Labour Force Survey 2008-2019 (SOWELL, 2021: 161)

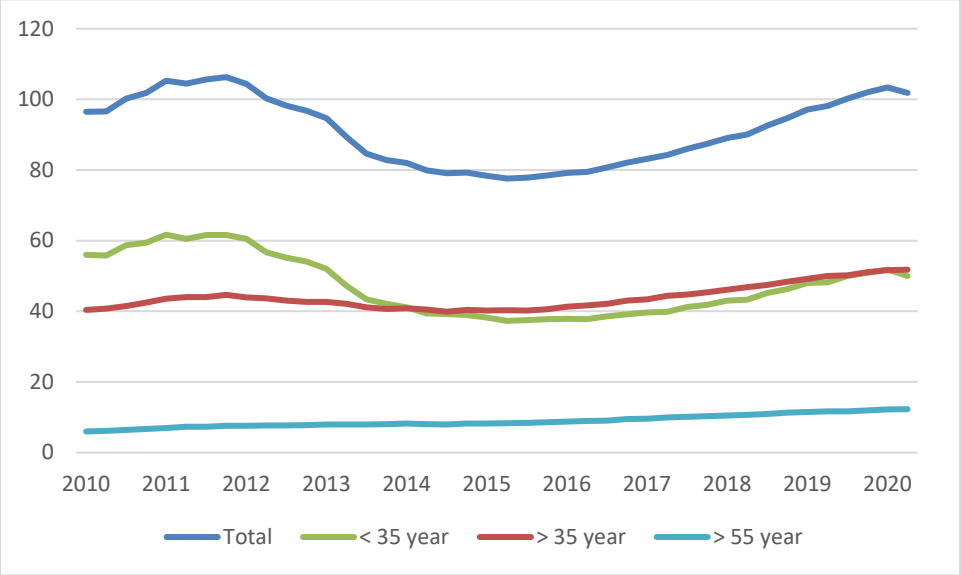
The share of older workers aged 50-64 years in the sector of Health and social work activities has increased substantially. From 27 percent in 2008, gradually to 35 percent in 2019. This development of ageing in the sector's workforce is similar to the situation in other European countries (SOWELL 2021: 128, 164). Another trend is the higher educational level in the sector. In 2008, 33 percent of the workforce in this sector was higher educated (tertiary levels 5-8) and in 2019 this share had increased to 43 percent, the same level as in the EU as a whole. Gender differences in the Netherlands are slightly bigger, with higher shares of men in the highest educational segment and lower shares of men in the lowest educational segment.

The quality of health care is highly dependent of the quantity, quality and performance of those working in the sector. At the same time, the labour market in the care sectors is under pressure. The demand for care has grown, is growing and will continue to grow. Despite the relative growth in the number of professionals, there is lack of professionals in the care sectors, which has negative effects on work pressure and sickness absence. Care professionals have had to deal increasingly with administrative tasks and regulations, which causes them to spend less and less time with their patients. Furthermore, they experience a lack of appreciation of their work and insufficient autonomy in their work (see further about the working condition in section 4). The Dutch labour market is nowadays very tight, also in the care sectors. Expectations are that the shortage of personnel will continue to grow in the coming years, also in LTC and ECEC.

1.2.2 Early childhood education and care (ECEC)

Nowadays, around 110,000 people work in the sector of Early childhood education and care (ECEC) in the Netherlands. 88,000 of them are pedagogical workers. Not less than 95 percent (!) of the workforce in ECEC are female. Figure 1.11 shows high fluctuations in the number of workers in ECEC: in the period 2012-2016, the number of workers decreased substantially. One of the reasons was a declined demand for childcare due to the growth of unemployment after the financial crisis, combined with the system characteristic that parents without jobs lose their entitlement to tax compensation for childcare (Van Hooren, 2021). A second reason was the large reduction in the tax bonus for working parents as part of the austerity policy of the government in 2011-2014 (Van Hooren, 2021). The sector started growing again after 2015 because of economic recovery and a small re-increase in the tax bonus. Figure 1.9 teaches us that fluctuations in the workforce are concentrated among the group of younger workers (younger than 35 years); including those on permanent contracts (see figure 1.12).

Figure 1.11 Number of workers in Early childhood education and care (ECEC), by age groups, 2010-2020 (x 1000)

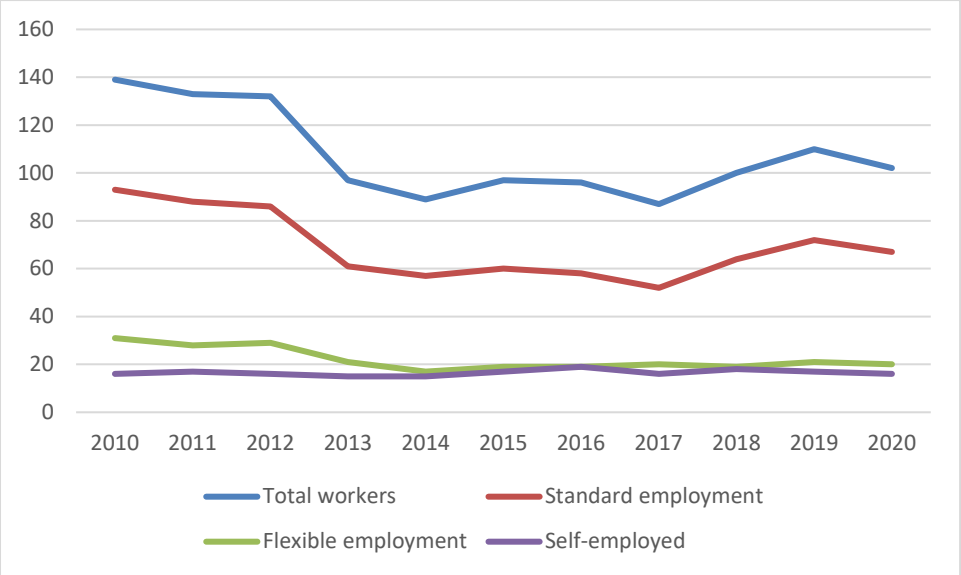


Source: CBS, Statline, AZW (note: category > 55 years is part of the category > 35 years)

High dismissal rates and temporary contracts in the ECEC sector have given the sector a bad image: also young people find job insecurity in their jobs unattractive, which makes it more difficult for the sector to find sufficient workers, even in better economic times (Van den Tooren et al., 2019: 128). Another (second) problem is that childcare centers experience a qualitative mismatch between supply and demand in the labour market due to the lack of people – mostly educators - with a specific education and specific skills, such as language and communication skills. Since 2018, the new 'Innovation and Quality Childcare Act' (*Wet Innovatie en Kwaliteit Kinderopvang, IKK*) requires different skills of existing and new personnel. Also municipalities set more requirements on day care centers with regard to the professional qualifications of their workers. But medium and higher educated child educators often expect more challenging environments (Van den Tooren et al., 2019). The high staff turnover in the sector is related to dissatisfaction with terms and conditions of employment, in particular the lack of career opportunities and education and training facilities (idem). Also salary levels are considered too low. To fulfill vacancies, childcare providers follow different strategies (see section 5).

Figure 1.12 shows the developments in types of labour contracts in the ECEC sector. In 2020, 16,000 self-employed and 20,000 workers in flexible employment contracts worked in the sector. Most flexible employment contracts are temporary contracts for a fixed period (11,000) and on-call/replacement contracts (6,000). Including self-employment, the total share of a-typical contracts in ECEC in 2020 was 35 percent (even excluding part-time work, which is not considered a-typical in the Netherlands). In 2010, the total share of a-typical contracts was also high: 34 percent.

Figure 1.12 Number of workers by contract in Early childhood education and care (ECEC), 2010-2020



Source: CBS Statline

1.2.3 Long-term care

In the beginning of 2021, around 450,000 people worked in the sector of Nursing homes and homecare. Since 2010 the total numbers have been fluctuating (fig. 1.13), but figure 1.13a shows that the subsector of residential long term care has been growing in the last 10 years, while the numbers of workers in the subsector homecare have been declining. Compared to the level of 2010, the numbers of workers in residential care have grown by 30 percent, while the numbers in homecare have declined by 20 percent.

According to the last available data, there are 46,275 nurses in the total LTC-care-sector in the Netherlands (which is around 12 percent of the total number of workers in LTC).[6] Compared to the ECEC-sector, we see lower shares of younger workers and higher shares of older workers in this sector. Especially the group of 55 years and older has grown in the last decade (see figure 1.13).

Figure 1.13 Number of workers in Nursing homes and homecare by age groups, 2010-2021 (x 1000)

[6] Medisch geschoolden; arbeidspositie, positie in de werkkring, 1999-2017 (cbs.nl)

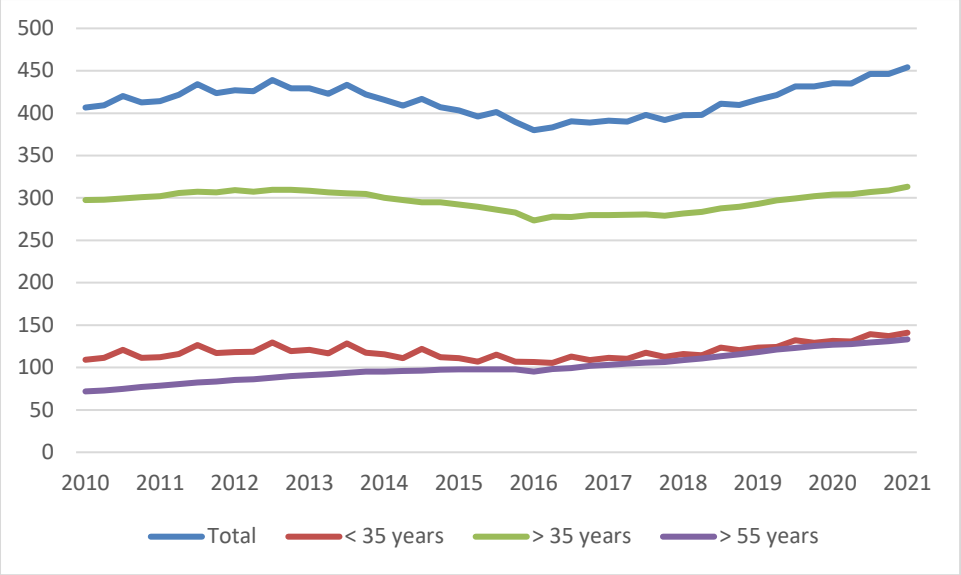


Figure 1.13a Number of workers in Residential long term care an Homecare, 2010-2021, all 3rd quartiles (x 1000)

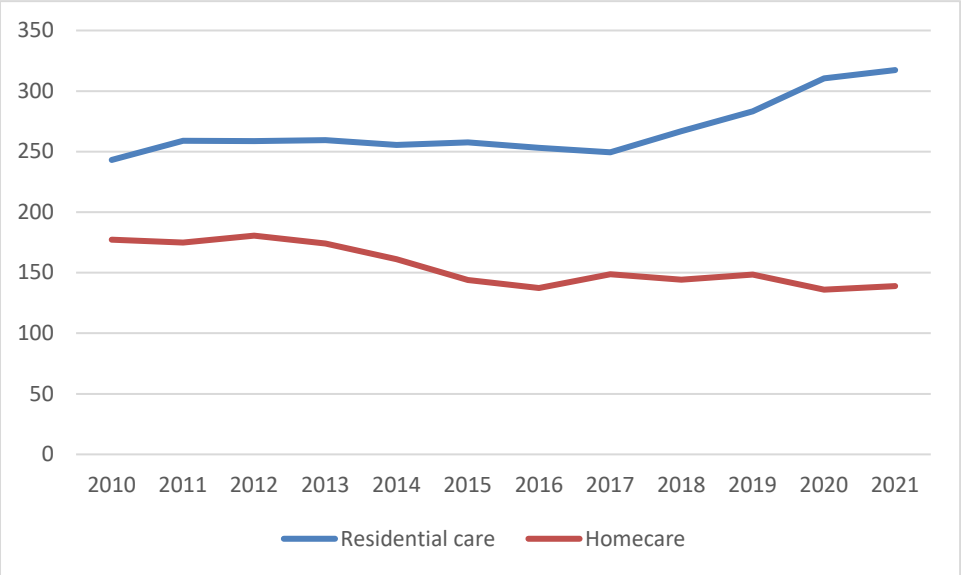


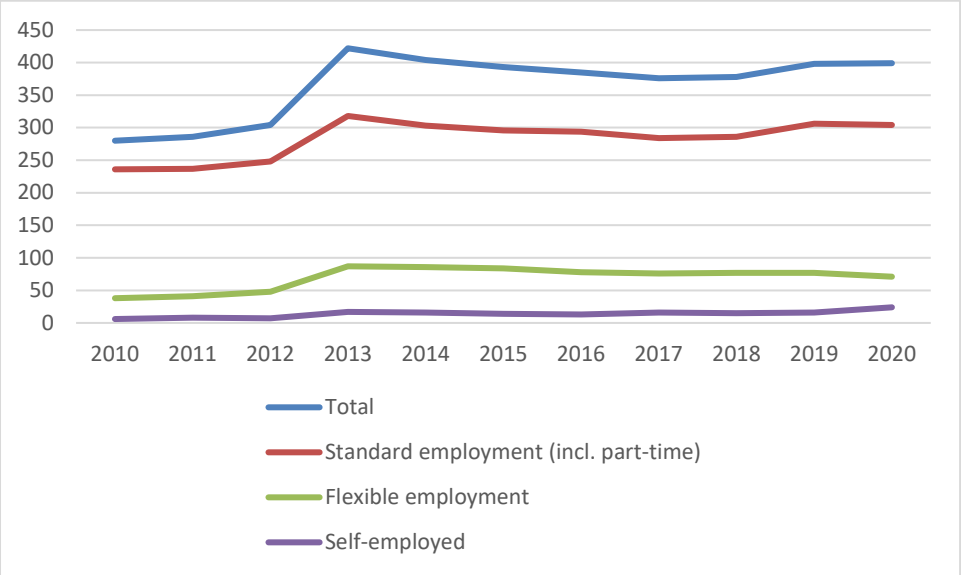
Figure 1.14 shows the numbers of workers and the evaluation of three types of labour contracts in the sector of Nursing homes and homecare in the years 2010-2020. In 2020, there were 304,000 standard employment contracts, 71,000 flexible employment contracts[7] and 24,000 self-employed workers in the sector.[8] A total of almost 400,000 workers. Shares of flexible contracts and self-employed workers increased significantly in the last decade:

[7] Most flexible employment contracts are temporary contract with limited duration (29,000) and on-call/replacement contracts (26,000).

[8] There were also 4,000 temp agency workers in 2019.

from 16 percent in 2010 to 24 percent in 2020. According to a survey commissioned by FNV (2022a), six out of ten care workers younger than 35 years is considering a switch from employment to self-employment or other flexible work. Such a trend might lead to a deterioration of the job quality for those in core employment, due to increasing workloads as a result of the lower numbers of core workers in organisations who are in addition charged with more coordinating tasks, and less continuity in the provision of care services (FNV, 2022b).

Figure 1.14 Numbers of workers by contract in the sector of Nursing homes and homecare LTC, 2010-2012 (x 1000)



Source: CBS Statline

Many workers in the sector of Long-term care (LTC) wish to leave their current employer in the near future. This is related to dissatisfaction with the working condition and terms of employment (see further section 4). LTC organisations experience a lack of personnel and difficulties in recruiting new staff, especially in regions where young people are emigrating and the population is ageing (Van den Tooren et al, 2019: 60). Employers in the sector are hindered by a bad image, partly due to their own restructuring practices in the last years. They have cut management levels (also in home care) and functions such as 'hospitality' and 'service' in the nursing homes. People in the latter functions were difficult to retrain.

Employers in the sector see a mismatch between required skills and available skills in the LTC-sector. They are looking for more entrepreneurship and performance-oriented competences, while (too) many workers prefer to 'care' in the human sense. LTC-organisations are plagued by persistent vacancies and follow different (innovative) strategies to solve their staffing problems (Tooren et al, 2019: 61). In addition, they invest in life-long learning for their workers in order to improve their stay in the organisation.

Especially in the LTC sector, the labour market will be tighter in the near future. A shortage of 90,000 healthcare workers is expected by 2030 (SER, 2020). This will lead to longer waiting lists for patients and challenges with regard to accessibility and quality of care services. In the Netherlands, a big wave of ageing is imminent, which will lead to the 'double challenge' of more demand for LTC services from the elderly and a decreasing supply of workers. This problem will even be reinforced by a decrease in the numbers of informal care givers due to the high labour participation of family members and others in the Dutch labour force.

2. ECEC and LTC services in the Netherlands

2.1 The ECEC and LTC system

2.1.1 Governance of ECEC services in the Netherlands

Childcare in the Netherlands has long been under the influence of a highly gender-related conservative culture (Van Hooren & Becker, 2012). Christian political parties in particular sought non-interference of public policies with family life and support for the male breadwinner model. Only in the early 1990s did public budgets for childcare triple and the percentage of children up to the age of three in daycare or guest parents care increase, from 5.7 in 1990 to 25.9 in 2006 (Van Hooren & Becker, 2012: 98-100). After political discussions about a collectively financed basic provision for all children versus a demand-driven system that subsidized parents who wished to buy childcare services on the market, the last mentioned model was implemented in 2005. Related to the 'part-time-economy' of the Netherlands, a relatively great part of childcare is still done informally (f.e. by grandparents) and by mothers who work part-time to take care of their young children at home. Although the reorganisation of ECEC care on a free-market basis is gaining ground in many Western countries, the Netherlands can be called a champion, together with the United Kingdom, Australia, Canada and New Zealand (Van Hooren, 2021).

The ECEC-system in the Netherlands consists of private daycare centers (*kinderdagverblijven*), which offer year-round care for children between birth and four-years-old up to five days a week, and home care by child-minders (*gastouderopvang*) for children between birth and 12. The main aim of the Dutch ECEC system is to support working parents, but for children aged 2-4 years, the so called *peuterspeelzalen* provides for educational development of the children as well (mostly for two day-periods a week).[9] This second aim of child-development has become more important in the last decades, together with the third related aim of combating unequal opportunities. At age four, children in the Netherlands are eligible for full-day kindergarten, which is part of the publicly funded

[9] Peuterspeelzalen are nowadays mostly as part of the day care centres.

primary school system and is free of charge. Children aged 5 and older must go to school and many daycare centers also provide for care for children before and after school time and during the lunch break.

The system for children younger than 4 years was privatized and marketized in 2005. The *Wet kinderopvang* (2005) aims to guarantee the quality of child development. In 2010, new legislation was introduced to harmonize the ECEC sector (Dutch Government, 2010): a single statutory quality framework was introduced for all types of ECEC, regardless of legal personality of the organisation and type of funding. The harmonized quality framework specifies age-dependent equal structural quality and health and safety conditions, and defines equal developmental goals and global curriculum guidelines for all ECEC services. Furthermore, in this harmonized system, all services are equally eligible for additional subsidy under the national educational equity policy to reach disadvantaged children and provide them with high-quality early education and care.

Despite several attempts of the government to improve and harmonize the sector's governance, ECEC has remained a 'patchwork' with fragmented objectives, provisions and funding (SER, 2016). An important Dutch characteristic of the childcare sector is the provision of services by private organisations: not-for-profit as well as for-profit. These organisations make their own tariffs (unlike the LTC-sector, as we will see later). Parents pay directly to day care centres and the Tax Service reimburses a part of these costs under certain conditions. Reimbursements are dependent on the income levels of the parents (the lower the income the higher the reimbursement). A recent survey showed that many parents are not aware of the level of their own final payments for these ECEC-services (Kok et al, 2020: 7). The tax service in the Netherlands has made serious and persistent mistakes in calculating the parents' costs and tax-reimbursements, leading to a deep public scandal and the fall of the government Coalition in 2020. Municipalities are responsible for the provision of special educational programs for children from disadvantaged families. Both *kinderdagverblijven* and *peuterspeelzalen* receive subsidies from the local governments to provide these services to a targeted group of families. Another Dutch feature of the childcare sector is the distinction between working parents and non-working parents (same as in England). Non-working parents have access to subsidized *peuterspeelzalen* and disadvantaged families are entitled to subsidized places in the special educational programs. However, tax reimbursements for childcare are only available for single working parents and parents who both work.

Below, we will add three special characteristics of the ECEC-system in comparative cross-national perspective. Firstly, children up to three years of age spend few hours in day care, (also) because many working mothers have a part-time job in the Netherlands. Secondly, children with low income parents make far less use of day care services than children from

high income parents. Thirdly, childcare before/after school-hours is not provided by the schools, but by daycare centers, and is not made much use of in the Netherlands.

In 2021 the tripartite Socio-Economic Council made a plan for reforming childcare in the Netherlands. The council recommended the government to provide for 2 days childcare a week for children from 0-4 years old, financial affordable for parents and including subsidies dependent on the income-levels of parents (relatively more financial support for lower and middle income families).[10] For the Netherlands where the level of childcare facilities is not very high, this is a step towards more investments. Nevertheless, the original plan for a universal system, including subsidies for families without working parents, was not adopted by the government, although such as system would better reflect the importance of the educational function of childcare for young children and its contribution to combatting inequality in the early life.

2.1.2 Governance of LTC-services in the Netherlands

Nowadays, the Dutch healthcare system is regulated by four Acts:

1. '*Zorgverzekeringswet*' (Zvw)- Health Insurance Act - for cure-services provided by hospitals, general practioners, cure clinics etc. (since 2006).
2. *'Wet langdurige zorg'* (Wlz) - Long-term Care Act - for long-term care services (since 2015).
3. *'Wet maatschappelijke ondersteuning'* (Wmo) - Social Support Act - for housekeeping services in homecare, protected homes for homeless people etc., all primary under the responsibility of the 400 municipalities in the country (since 2007, with reform 2015).
4. *'Jeugdwet'* - Youth Act - for short- and medium-term care and social support for the youth, primary under the responsibility of the 400 municipalities in the country (since 2015). Long-term mental care for the youth is regulated under the Long-term care Act.

The first and second acts consume by far the biggest healthcare budgets in the Netherlands, respectively 44 percent and 20 percent (see also figure in 2.2).

In the 21st century, the Dutch healthcare system was subject to two large legislative reforms. The first reform was in 2006, with the 'regulated privatization' for cure-services and increased involvement of private insurers. Because ECEC and LTC services are mainly outside the scope of these cure-services and the related insurance reform, we skip here further analyses of this reform (see f.e. Batenburg et al. 2015). The second large reform took place in 2015 – with a first step already in 2007 - and was directly targeted to long-term care in nursing homes, homes for elderly people and peoples home (Maarse & Jeurissen, 2016).

[10] To be elaborated later to those in the age group 4-13 years.

The core of long-term care services in intramural settings is since 2015 covered by the Long-term care Act and is strictly aimed at the most vulnerable groups of people. This includes the large group of elderly with dementia, but also people with serious physical or mental disabilities and people with psychiatric disorders. A national agency provides referrals to qualify for these kind of intensive services (CIZ, *Centrum Indicatiestelling Zorg*). Services can be provided in intramural settings – such as in nursing homes, homes for the elderly, psychiatric clinics – but also though homecare or combinations of the two (for example staying at home at night and treatments and activities in centers during the day). Local agencies - '*zorgkantoren'* - organize the provision of needed services as indicated by CIZ and act as intermediary between service providers and clients. The state regulates and inspects the quality standards with respect to the service providers. For support in the households, citizens must apply to their municipalities (Social Support Act).

The reform of long-term care

This section will go more into the policy-theory behind the LTC reform. To put a halt to growing expenditures, in 2007 several types of homecare (home-help, councelling) were transferred to the municipalities and other LTC-budgets were effectively frozen. Municipalities became responsible for non-residential care and coverage of housekeeping services was shifted to the new Social Support Act with substantially budget cuts. It was assumed that municipalities would be able to provide care more efficiently and tailor it better to the needs of recipients, since they are closer to citizens and, more importantly, since this meant that the rights-based approach of the former Exceptional Medical Expenses Act (Awbz) would be replaced with a compensation-based approach under the Social Support Act (Batenburg et al., 2015).[11] The Social Support Act intends to create 'a more inclusive society and to promote independence and societal participation for people with impairments/disabilities or chronic psychological or psychosocial problems'. Since 2007, the hope has been that less costly home-based support would enable people to continue living in their own environment for as long as possible and participate in society. In 2015 a more radical and broader reform in the LTC sector was implemented (Maarse & Jeurissen, 2016). This reform had four interrelated pillars: a normative reorientation towards more individual responsibility in arranging services, a shift from residential to non-residential care, decentralisation of non-residential care and expenditure cuts (Maarse & Jeurissen, 2016; Batenburg et al., 2015). Long-term care continued to be largely publicly funded and a statutory health insurance scheme will remained in place for persons who really need residential care.

[11] It has to be said that in 2008, extra funds were made available for long-term care that was not transferred to the municipalities: €340 million was reserved for 5000–6000 additional long-term care nurses, for the provision of daytime activities for people with disabilities, and to increase the volume of long-term care (Ministry of Health, 2008).

Together with the introduction of the Long-term care Act in 2015, a new Social Support Act in 2015 decentralized more responsibilities from the national state towards the individual municipalities. Municipalities became responsible for care provisions such as homecare, protected homes for homeless people, people with mental disorders and victims of domestic violence, or financial support for people with chronical diseases. The Youth Act (2015) made municipalities responsible for providing care and support to young people (and their families) with grow-up and educational problems and mental disorders. These services continued to be financed by public funds, but now through the municipalities (*Gemeentefonds*). In contrast to the LTC-act, national solidarity is limited in the Social Support Act and in the Youth Act, due to the major differences in access to and quality level of services among municipalities. One could say that solidary is (only) based on all inhabitants of a municipality (ZonMw, 2018).

2.1.3 Care services provision and their quality

This subsection is about access and quality of ECEC and LTC services. The European Pillar of Social Rights states that people in the EU should have access to good quality childcare, healthcare and long-term care. For childcare, it emphasizes that children from disadvantaged backgrounds have the right to specific measures to enhance equal opportunities. For long-term care, the emphasis is on homecare and community-based services. Access to these services contributes to reducing inequalities throughout the life cycle and achieving equality for women and persons with disabilities (Eurofound, 2020).

ECEC

Studies showed that the Dutch model in ECEC tends to strengthen unequal access to high-quality ECEC, favoring high income groups, and withdrawal of provision from remote, rural or poor areas with low purchasing power (Kok et al. 2020; Noailly and Visser 2009). The privatized demand-driven model of ECEC-service provision challenges childcare organisations to reconcile divergent public and private objectives in a single organisational configuration (Van der Werf et al, 2021). Private parties are responsible for public tasks but, in combination with increased freedom of choice, this also leads to differentiation between organisations in their quality and pricing of ECEC-services (idem).

Access to and participation in childcare is the highest in the age group of 2-3 years (see figure 2.2). Recent investigations have indeed shown that lower educated mothers make less use of child care than higher educated mothers in the Netherlands (Kok et al., 2020). The inequality is especially high among children up to 1 year old (43% among lower educated mothers versus 71% among higher educated mothers). Among children aged 2 and 3 years, this inequality is less sharp thanks to the subsidized provision of ECEC by the municipality for children aged 2 or 3 years (69% among lower educated mothers versus 86%

among higher educated mothers). In international comparisons, access in ECEC is high (after a very slow start in the history), but for less hours.

The quality of ECEC services is dependent on several factors, such as:

- Education and professional skills of the workers;
- Group-size of the children;
- Emotional quality/interaction between workers and children;
- Educational quality/provision of activities to stimulate cognitive development.

Pedagogical staff working in ECEC are required to have an upper-secondary vocational education level 3 (*MBO-3*) degree covering certain topics relevant to the development of a child.[12] In homecare by child-minders (*gastouders*) upper-secondary vocational education level 2 (*MBO-2*) is required (just since 2010). These requirements in the Netherlands seem quite low compared to f.e. Germany and Sweden (Van Hooren, 2021).
Group-sizes are regulated by legislative standards in the Netherlands in the ratio between worker and numbers of children (*Wet Innovatie en Kwaliteit Kinderopvang*). 1:3 for babies and 1:8 for kids aged two and three. However, at the age of four, children already go to school, where groups are much bigger.
Scores on indicators for emotional and educational quality of ECEC services in the Netherlands seem to be on EU average levels or a bit higher (OECD / Slot, 2018). The majority of children from disadvantaged families participate in daycare centers that have higher quality programs, which is better than in many other countries (Kok, 2020: 11).

For children from 2.5 to 4 years from disadvantaged families, day care centres provide for special educational programs (voorschoolse and vroegschoolse educatie, VVE). In the Netherlands, children must obtain an official assessment or indication to attend a day-care center for children with a language deficiency or disadvantage.[13] This is obtained at the municipal level via a designated department or consultation office and the assessment is often carried out at a youth and family center (*Centrum voor Jeugd en Gezin*) or similar organisation.

LTC

The Netherlands belong to the countries in Europe with the highest access in terms of proportions of people who use some type of formal long-term care service, including residential care, nursing care provided at home, and home help or personal care (Eurofound, 2020: 52). This is also reflected by statistics on the share of spending on formal long-term care services for the elderly, together with countries as Sweden and Denmark

[12] This paragraph is based on (Eurofound, 2020: 24), it has to be checked later in the interviews with social partners in the sector.
[13] Krijgt mijn peuter of kleuter voorschoolse of vroegschoolse educatie (vve)? | Rijksoverheid.nl

(OECD 2020: 164, see further section 2.2). Long-term care services in the Netherlands, also after the reforms in 2015, are still large and elaborated, while the Dutch population is relatively speaking still not that aged (SER, 2020). Citizens in the Netherlands are worried and concerned about the quality of care for the elderly, and more general about the lack of personnel, high work pressures and low salaries in the sector (SCP, 2019). The SER (2020) questions whether the current quality levels can be guaranteed in the future as ageing of the population in the Netherlands continues? Not only because of barriers in de labour market but also because of financial sustainability.

As described in 2.2.2 the governance of long term care and social support aimed at more market-mechanisms between the triangle of care agencies / municipalities, long-term care providers and clients. Since 2019, the government recognizes disappointed performance due to these market mechanisms in LTC: i.c. too much focus on individual interests of the stakeholders, on profitmaking and fragmentisation in contracts (VWS, 10 juli 2019). The Minister's credo is no longer 'competition' but 'co-operation between providers in the care sectors'.

Most clear are the negative effects of the decentralization – combined with cuts in public budgets and the introduced model of public procurement in the Social Support Act (2007 and 2015): 'municipalities have concentrated on organizing the Act in their local settings, and have been less concerned with the results achieved; concepts such as 'appropriate support', 'independence' and 'participation' are moreover not easy to define and measure' (SCP, 2018: 203). Also the SER-report (2020: 172-174) points to governance problems such as high bureaucracy and administrative burdens for municipalities and homecare providers in the model of public procurement. Our interviews with *FNV* (trade union) and *Iederin* (clients' organisation in homecare) point to low-cost competition between providers in homecare and related low quality of the services, and lack of knowledge in many smaller municipalities about homecare and public procurement.

2.1.3 Social transfers and tax incentives

ECEC

Childcare in the Netherlands is paid by the government, employers and parents. The Netherlands seems to be the only country with a legal obligation for employers to contribute financially. The employer is obliged to pay 1/6th of the daycare costs for every parent (so 1/3 in total). This is done by employers' premiums in sector funds. Every employer in the Netherlands is a mandatory member of a sector fund. Parents receive their employers' contributions together with the government's contribution in one time through the Tax Service. Relatively speaking, Dutch parents pay high own contributions for childcare.

In the recent history, the parents contribution fluctuated highly as a result of changing policies of the government. In 2008, parents paid only 18% of the childcare costs. But because of the governments' austerity measures after the financial crisis, parents' contributions increased to 40% in 2013. Public subsidies increased after 2015 and parents contributions could be lowered to 30 percent. The financial system is not transparent for the parents and in 2021, severe failures in compensating parents for childcare costs through the tax system has been one of the main reasons for the coalition government's fall (*kindertoeslag affaire*). Some parents had to refund huge amounts of money to the Tax Service, leading to financial drama in the families concerned.

LTC

Every citizen in the country and everyone who pays wage taxes in the Netherlands is obliged to be insured for intensive long term care and is covered for the related care services provision and costs, as regulated in the Long-term care Act. This uniform obligation is one of the pillars of the solidarity in the healthcare system of the Netherlands. The Long-term Care Act is a public national insurance, meaning that insurance-premiums are dependent on the income-levels of citizens and that these premiums are deducted from income taxes. People with an annual income under € 37,855 (2019) are entitled to a financial contribution from the state through the tax-system (*zorgtoeslag*). A smaller part of the LTC-costs is directly paid by the national state for earmarked purposes. Another smaller part of the services is paid by own contributions from the users, dependent on their incomes (and also related to factors as living at home/institution, younger/older than 65 years, and household situation). All financial contributions are collected in one Fund for long-term care, managed by '*Zorginstituut Nederland*'. The State makes extra contributions to the Fund when needed.

Financing of services can be 'in kind' or in 'personal budgets'. The Netherlands has a system of personal budgets ('*persoonsgebonden budget''*) where clients can buy themselves tailor-made care services. These personal budgets are used quite a lot for LTC-services and the provision of social support and youth care. In 2018, € 1,900 million of these budgets was spent on LTC services, € 425 million was spent on social support and € 180 million on youth care.

2.2 Expenditure for the ECEC and LTC services

The total expenditures in care (health/social services), including childcare, are according to Dutch statistics 108 billion Euro in 2019.[14/15] The yearly costs per head of the population increased from 2,500 to 6,120 Euro in the period 1998-2019. This includes collective

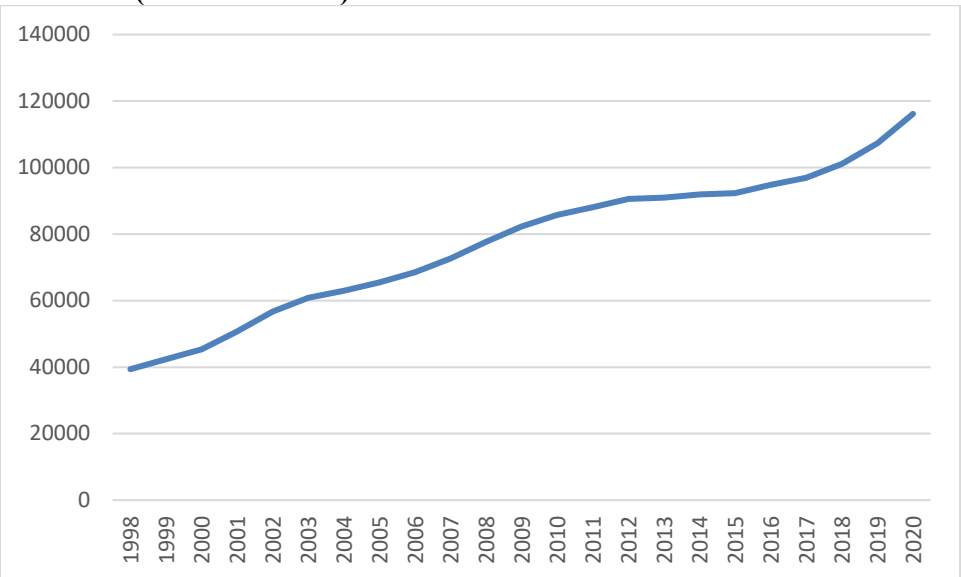
[14] StatLine - Zorguitgaven; kerncijfers (cbs.nl)

[15] This includes more expenditures than is calculated in international definitions, such as the System of Health Accounts (SHA).

contributions from employers and government, but *not* the private household contributions in obliged collective insurances, voluntary extra insurances and own contributions for care services. The care expenditures from taxes and collective insurances are controlled by a maximum ceiling of care expenditures (*Uitgavenplafond Zorguitgaven*). The Netherlands are listed around the 9th place in term of shares of (wider) health/care costs, namely 10.1 percent of the Gross Domestic Product.

Figure 2.1 shows that expenditures in care have grown in the last 2 decades. In the 2000s, expenses grew faster because of investments to eliminate longer-standing waiting lists. Nevertheless, in 2012-2015 expenditures grew more slowly as a result of public austerity measures, which can be seen as a delayed response to the financial crisis that started in 2008. Relative to the growth of GDP in the Netherlands, the expenditures even decreased after 2013. After 2019, care expenditures, as defined in the Netherlands, as share of the GDP grew again from 13.1% in 2019 to 14.5% in 2020 as a result of the corona pandemic.[16] In contrast to international definitions, the national definition of care expenditures in the Netherlands includes social care/support, ECEC and all care/support for the elderly.

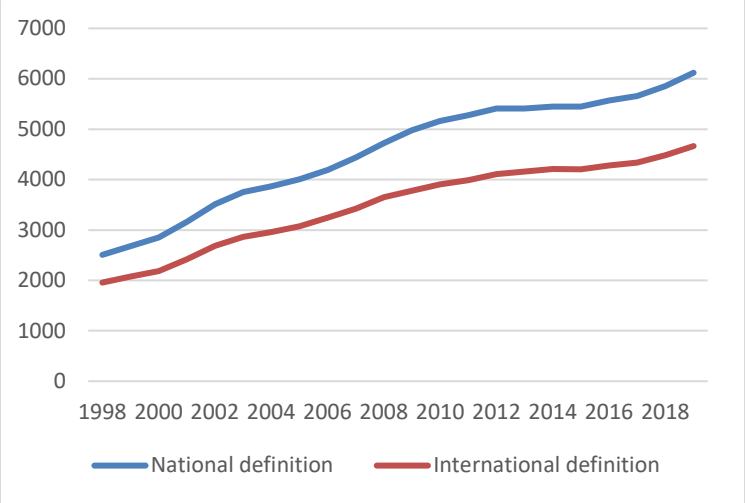
Figure 2.1 Total care expenditures in the national definition of the Netherlands, real prices, 1998-2020 (x million euro's)



Source: CBS Statline (sept 2021).

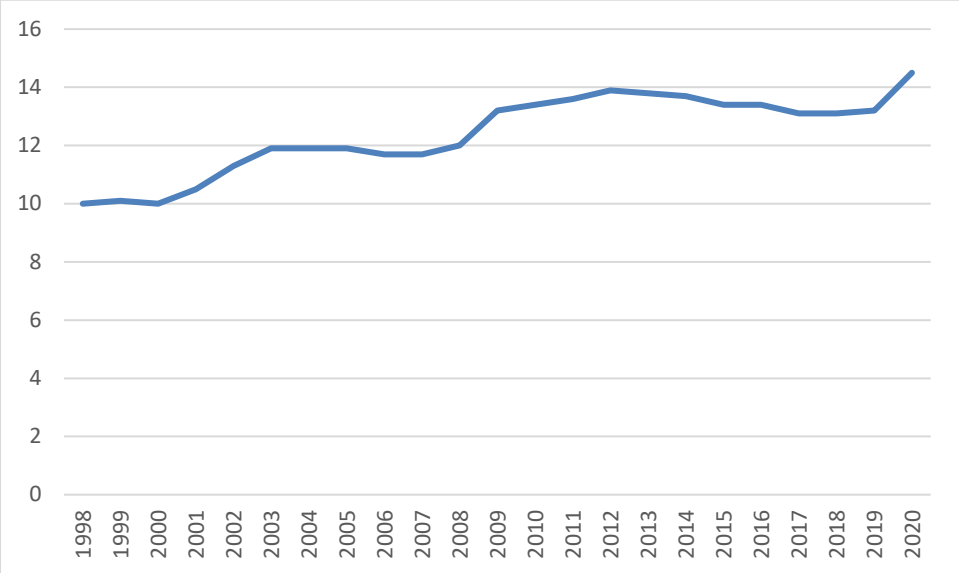
Figure 2.2 Care expenditure head of population, national and international definition, 1998-2019

[16] Zorguitgaven, inclusief steunmaatregelen, stegen in 2020 met 8,3 procent (cbs.nl)



Source: CBS Statline

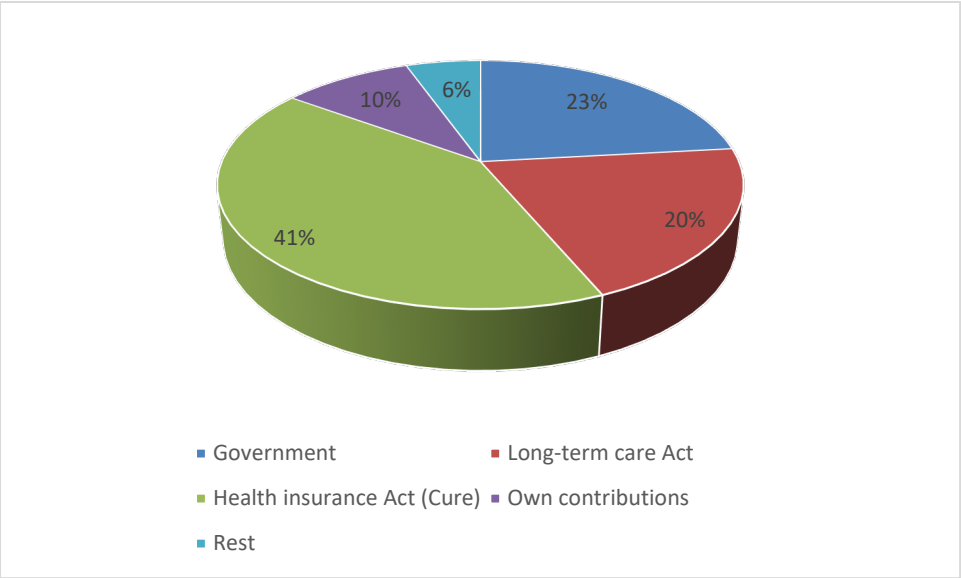
Figure 2.3 Care expenditures as percentage of gross domestic product, 1998-2020 (national definition)



Source: CBS Statline (september 2021)

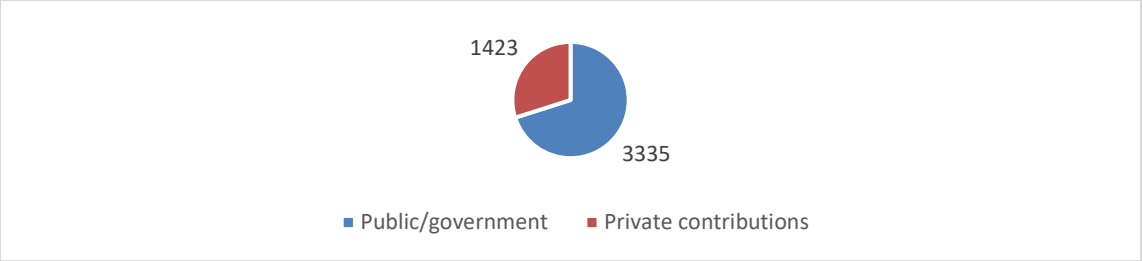
In 2020, the expenditures for health and care were € 6,600 per person (see fig. 2.4). These were financed for 41 percent by the Health Insurance Act (cure), 20 percent by the Long-term care Act, and 23 percent from contributions from the government. Private households paid 10 percent. The rest (6 percent) is paid from additional insurances and companies. The share of public finances – both from the government as the two obliged national insurances - was 85 percent in 2020.

Figure 2.4 financing of care expenditures in the Netherlands in 2020, per person (average)



In 2019, the total costs of ECEC were € 4,758 million.[17] Seventy percent paid by public money and thirty percent paid by private contributions of the users (figure. 2.5). More public investments in this sector are discussed (SER, 2021a: Advies 21/07).

Figure 2.5 ECEC costs in 2019, public-private contributions



Source, CBS, Statline

The total costs of LTC in the Netherlands were € 23,638 million in 2019, including personal budgets (Nederlandse Zorgautoriteit, 2020). It is generally expected that expenditure on LTC will increase due to the ageing of the population and the combination of high labour intensity.[18] LTC is relatively little influenced by the high cost-drivers of technological innovations in the cure sectors, but technological improvements can support longer living at home instead of living in (more expensive) old people homes or nursing homes (SER, 2020: 55-59). The costs related to the Long-term Care Act are expected to grow from 2.5 percent of GDP 2017 to 3.2 percent in 2025 (idem: 62).

[17] StatLine - Zorguitgaven; zorgaanbieders en financiering (cbs.nl)

The SER (2020) points to several instruments to control expenditures in LTC. Firstly and most important, limitation of the annual macro-budgets by the State. In contrast to curative health, overspending in LTC cannot be paid by the care providers themselves. Secondly, influencing the demand for care services; access can be made more difficult by giving only patients with very high needs access to LTC, or own financial contributions can be increased.

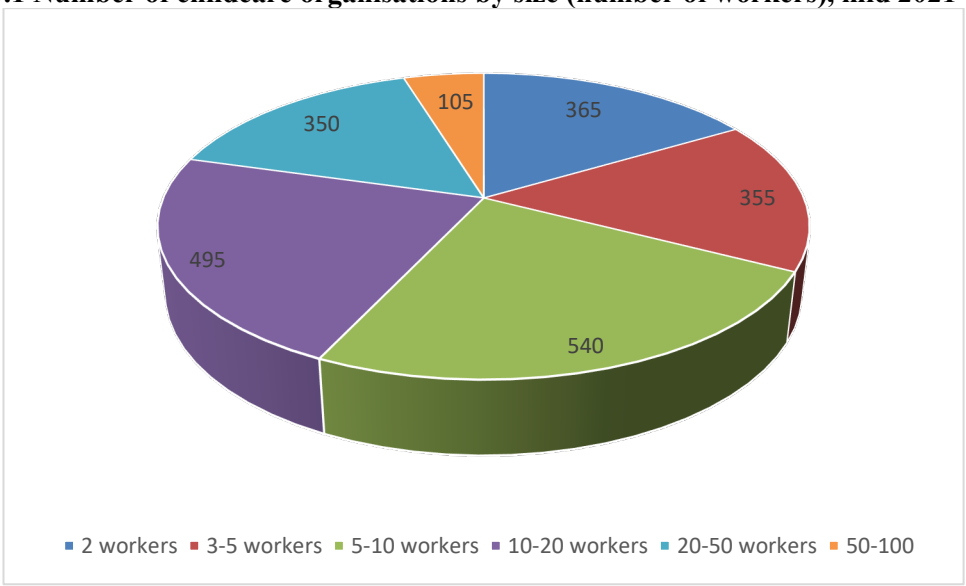
2.3 Main service providers

ECEC

The Netherlands have a mixed system of providers, with a relatively large share of profit organisations (similar to the system in the UK). The demand-driven model of childcare in the Netherlands – introduced in 2005 - has indeed led to more 'for profit' organisations: from 40% in 2003 to 70% in 2010 (CPB, 2011). Providers vary from very small businesses to large companies, owned by private equity funds (Van Hooren, 2021). In 2011-2014 the number of bankruptcies was high due to the high sensitivity to economic factors of the Dutch childcare model: unemployment leads to losing the right to subsidy and austerity policies lead to lower public contributions and higher prices for parents.

Mid 2021, there were 12,300 companies in childcare. Most of them were run by 1 person: 10,090. Figure 3.1 shows the numbers of childcare organisations with more than 1 worker (in total 2,210). Most of them are SME's with less than 50 employees. There are 105 larger providers with more than 50 workers in the Netherlands.

3.1 Number of childcare organisations by size (number of workers), mid 2021

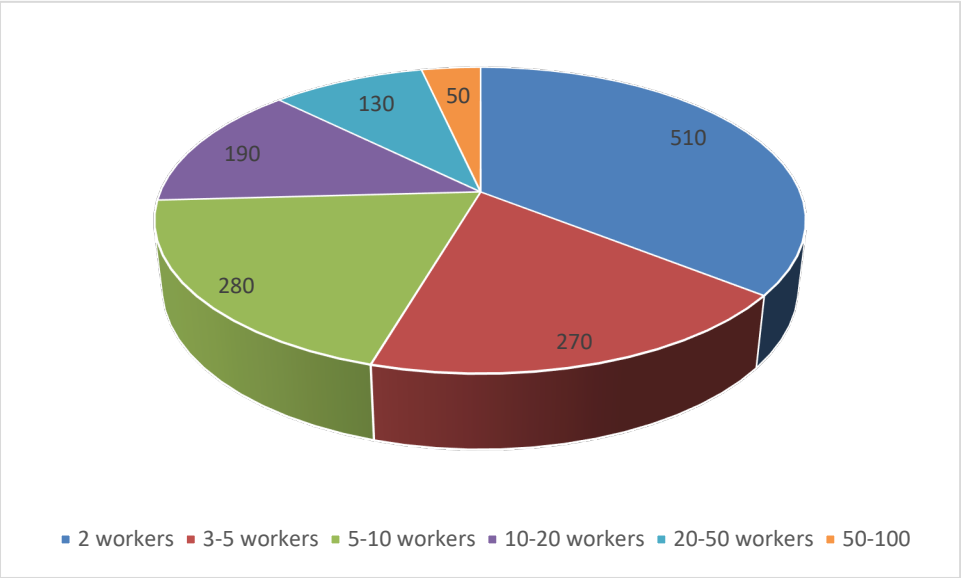


CBS, Statline

LTC

Mid 2021, there were around 2,300 homecare organisations. Most of them were run by 1 person (21,605). Figure 3.2 shows the number of homecare organisations with more than 1 worker; in total 1,430. Compared to childcare organisations, homecare organisations are even smaller. Just 50 companies in the homecare sector have more than 50 employees.

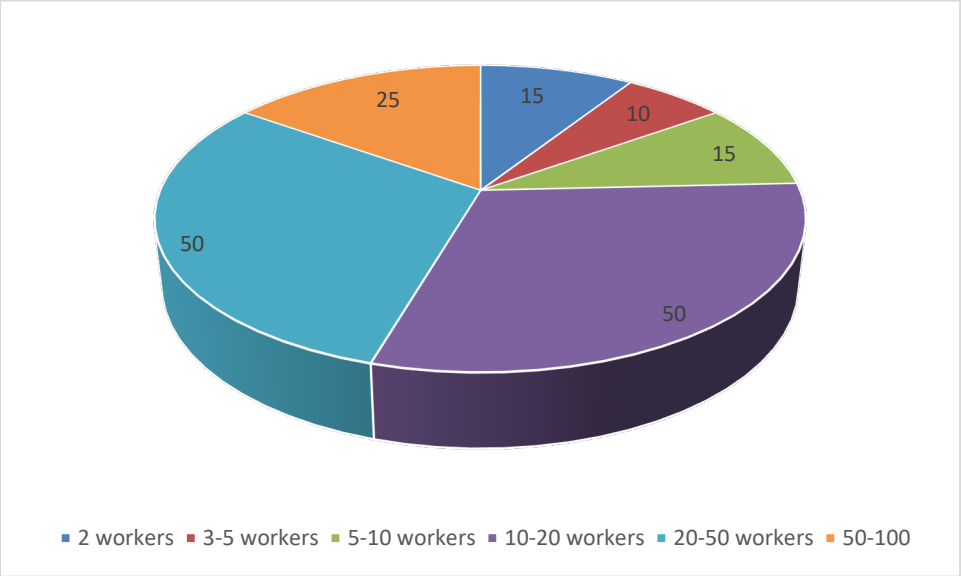
3.3 Number of homecare organisations by size (number of workers), mid 2021



CBS, statline

The size of nursing homes (fig. 3.4) is larger than that of childcare and homecare organisations in the Netherlands.

3.4 Number of nursing homes by size (number of workers), mid 2021



CBS, statline

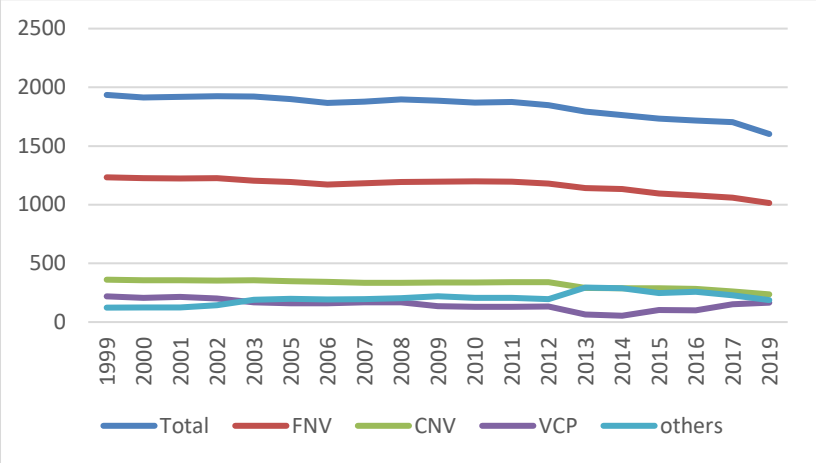
3. The employment relations system in The Netherlands

3.1 The main characteristics of the employment relations in the public sector

Trade unions

Trade unions in the Netherlands are institutional established organisations that participate in the national social dialogue and in collective bargaining in private and public sectors. The right to strike is a basic right. In case of labour conflicts, judges stress the importance of the freedom of collective bargaining and collective action (Barendsen,2016). Not only the willingness to engage in collective action has declined, also the overall net unionisation rate of employees in the Netherlands shows a downward trend: from 28% in the mid-1990s to around 24% in the 2010s (Cruchten & Kuijpers, 2007). Figure 3.1 shows absolute declining figures of trade unions' memberships during the last two decades. In the 21st century, the total number of union members across all sectors has declined further to 1.6 million in 2019.[19] Compared to the private sector, public sector unionisation is higher than average, but recent data on net organisation rate are not available. In 2004 the net organisation rate was 39% in the sector of public administration and 24% in the health and care sectors (Cruchten & Kuijpers, 2007).

Figure 3.1 Absolute numbers of memberships in trade unions in the Netherlands, 1999-2019



Source: CBS

Employers' associations

Employers in the Netherlands are more organized in business and employers' associations than workers, although the organisation rate also seems to decline on this side. In the healthcare sectors, it is estimated that 61 of the companies were organised in 2010, and 54

[19] StatLine - Historie leden vakverenigingen (cbs.nl)

percent in 2019 (TNO 2011; TNO 2020). This is still higher than the national average of 45% membership of employers' association in the Netherlands (idem). Theoretically, terms and conditions of workers in the public sectors are set unilaterally by public organisations, although trade unions must be consulted and agree with collective agreements. This is based on good customs and protocols (Barendsen, 2016). The Dutch public sector in its narrow definition includes: central government, regional and local government (municipalities), the judiciary, the district water authorities, education, the security forces and police, and university hospitals. So the LTC and ECEC sectors are not included in the public sector. The LTC sector can be seen as part of the not-for-profit and subsidized (by tax or public insurances) organisations, together with parts of the education sector, housing sector and other health/care sectors (excluding university hospitals). Remarkably, in these semi-public sectors, collective bargaining is not very different from collective bargaining in the private sector, although there is one big difference: the budget for salaries and wage improvements is limited by a financial ceiling set by the Ministers. For the health sector, including the LTC sector, this is done by the Minister of Public health, Welfare and Sport (see later).

Social Dialogue at national level

At first sight, formal institutions in industrial relations in the Netherlands have remained more or less unchanged in the last seven decades. Just after the Second World War, bodies in the national social dialogue were established, with trade unions and employers' organisations playing an important role through their seats in the tripartite Socio-Economic Council (SER) and the bipartite Labour Foundation (STAR) at the national level. In the period 1980-2020, social partners still had their seats in these bodies, but their actual functioning went through a gradual transformation, with the system having less impact than before (De Beer & Keune, 2018). The last years saw an increased social dialogue within the SER about financial and labour-related issues in the sector of healthcare, with involvement of trade unions and employers' associations in the health and care sectors.

Collective bargaining and collective agreements

The Dutch collective bargaining system covers around 80 per cent of all employees in the Netherlands. This percentage has been fairly stable over the past decades. Nevertheless, it is important to mention that (bogus) solo self-employed and freelance workers are not registered as 'employees' while these shares of workers increased substantially from 8 percent in 2003 to 12 percent of all workers in 2019.[20] Solo self-employed workers are by definition not covered by collective agreements. Collective bargaining coverage is strongly supported by the fact that most of the sector agreements are extended quasi-automatically to the entire industry by the government (on condition that 60 percent or more of the employees in the sector are working in companies that are member of the employers'

[20] Ontwikkelingen zzp (cbs.nl)

organisations that entered into the sector agreement). Because of this legal mechanism, most sector agreements bind all employees in a specific sector, with some exceptions, such as public top-level managers or medical specialists, many of whom are self-employed. In total for the Netherlands, around 17 percent of the employment under sector bargaining is covered as a result of this legal extension mechanism (SZW, 2020). Sector bargaining prevails over company bargaining: around 88 percent of all workers under collective bargaining are covered by the sector agreement instead of a company agreement. Collective agreements in the Netherlands – both in private and public sectors - usually have a term of between 1-2 years, so also in ECEC and LTC sectors. The law regulating collective bargaining stipulates that the validity of the current agreement is prolonged automatically if no new agreement is concluded before it expires.

The characteristics of the Dutch employment relations have been institutionally (and at first sight) relatively 'stable' since the 1982. In this year, the government threatened to intervene in collective bargaining if unions would not moderate their claims for wage increases. Following this threat, the unions agreed to limit wage increases in order to restore profits. In return, various forms of work-sharing were introduced, including a shorter work week and part time work. This agreement is known as the Agreement of Wassenaar and formed the start of the Dutch 'polder model' (de Beer & Keune, 2016).

Since 1982, the institutions in the Dutch industrial relations have been quite stable and are characterized by (i) no government intervention in sectoral collective bargaining; (ii) limited increases in collective wages, (iii) willingness to seek compromises between employers and trade unions; (iv) stable and high bargaining coverage (ibid.; 222).

3.1 The main characteristics of the employment relations in the Dutch ECEC and LTC sectors

See section 5.1 about main actors, characteristics, relevance in the employment relations system and power

See section 4.1 about regulation of terms and condition of employment in the two subsectors.

Chapter 4: The working conditions in the ECEC and LTC services in the Netherlands

This section discusses the working conditions of the ECEC and LTC services in the Netherlands. First, we focus on the terms of employment by giving an overview of the relevant collective agreements in each sector, their content, and any additionally relevant regulation. The second section considers the working conditions employees in both sectors experience in practice. While the first section is primarily based on content analysis of documents and only supplemented with interview data, the reverse is the case for the second section. Hence, in discussing the working conditions of employees in the ECEC and LTC sectors, we rely on the overlapping consensus between social partners and governments to give us a general picture of what it means to work in each sector. The disagreements and points in dispute regarding the working conditions are also outlined, although the strategic positioning (i.e. the positions from which they derive their perspectives on working conditions) of the social partners will be outlined in the next chapter.

4.1 Regulation of terms and conditions of employment in the two subsectors: main collective agreements applied and relevant legislation

Collective labour agreements in the Netherlands are mostly agreed upon for a one- or two-year period. Moreover, the agreements made between unions and employers' organisation at the sector level are usually declared generally binding for non-organised employers (and also non-unionised workers) by the Ministry of Social Affairs and Employment. There are currently exceptional circumstances in the collective bargaining system in both the LTC and ECEC sector.

4.1.1 Regulation of terms and conditions of employment in the Dutch ECEC Sector

The previous collective labour agreement in de ECEC sector was signed by both 'general' unions – the FNV and CNV – as well as employers' organisations BK and BMK. However, the largest general union, the FNV, has withdrawn from the negotiations on the current agreement, because it did not agree to the required flexibility of staff and the limited increases in wages. The agreement by CNV employers' organisations BK and BMK has received its 'generally binding' status in January 2022. This agreement is known as the 'collective labour agreement childcare 2021-2022' [cao Kinderopvang 2020-2022]. In 2021, BvoK challenged the decision to make the collective agreement between CNV and BK/BMK generally binding because they signed their own labour agreement with a so-called 'yellow

union' LBV.[21] This agreement is known as the 'collective labour agreement small- and medium sized enterprises childcare 2021-2021' [cao mkb Kinderopvang 2021-2023]. This cheaper labour agreement was meant to be applied to organisations that are a member of the BvoK, but it has no legal effect anymore because of the government's decision to make the agreement between CNV and employers' organisations BK and BMK binding for all employers and employees in the ECEC sector.

This situation is possible due to the somewhat paradoxical institutional position of labour unions in the Dutch social dialogue. On the one hand, their institutional power is rather strong due to fact that collective labour agreements signed by unions are declared generally binding by the ministry, regardless of the coverage of unions. On the other hand, the only requirement made by the government is that the employers' organisations represent at least 60% of the workers in the sector. There are no requirements on the unions, aside from their formal status as a union. This means that employers organisations can sign a collective labour agreement with whichever union they wish, no matter how small or unrepresentative this union is (De Beer & Keune, 2017). The BvoK has made use of this situation and found the yellow union LBV willing to sign their proposed agreement despite their almost non-existent coverage. In fact, the BvoK actively sought out this 'yellow union' because they did not 'want to be stuck' to traditional unions. Moreover, they 'did not even bother to inquire into the coverage' of this union, as they feel that the other unions are 'just as unrepresentative'. But as written before, BvoK did not succeed in its complain about the other agreement towards the Ministry of Social Affairs and Employment.

The largest union in the Netherlands – which is active in almost all major sectors including the ECEC and LTC sectors – the FNV stresses that this institutional weakness has led to the rise of 'yellow unions' and the deterioration of terms of employment across the sector. Since these yellow unions are 'just a union in name, but without any representation of actual employees' this means that 'employees can simply be brushed aside in the negotiation process'. These yellow unions nevertheless survive by cashing the check of the 'employer's contribution' – a financial bonus received by unions that successfully sign a collective labour agreement with employers representatives. According to the FNV, the rising influence of such unions constitutes a commercialization of collective bargaining: 'No one joins these "unions" because they are unknown to the general public and not active for their "members". All they do is sign [collective labour agreements] and cash the check. [..] It is simply a business for them." (Negotiator FNV – ECEC sector). According to the FNV, the rising influence of such unions constitutes a commercialization of collective bargaining: 'No one joins these "unions" because they are unknown to the general public and not active for their "members". All they do is sign [collective labour agreements] and cash the check. [..] It is simply a business for them." (Negotiator FNV – ECEC sector).

[21] Yellow unions are unions that 'in fact function mainly for the purpose of protecting employer's interests' despite appearing as a worker's organisation (Rycak, 2021; 51).

The two collective labour agreements in the Dutch ECEC sector are quite different. The labour agreement childcare 2021-2022 signed by CNV, BK and BMK is over 200 pages long as covers:

- ✓ Definitions and determination of labour relations
- ✓ Working hours, working days and worktimes
- ✓ Wages and other financial benefits for employees
- ✓ Holidays, paid leave and sickness leave
- ✓ Conditions of employment and social policy
- ✓ Possibilities for inflow of professionals and professional development
- ✓ Worker representation (OAK, 2021; 4-6)

From the perspective of the CNV, the main improvements in this agreement compared to its predecessor is the wage increase for employees (averaging 3%), as well as the clear arrangement concerning the 'non-groupbound hours' of pedagogical staff, limiting the build up of 'max- and min-hours' (i.e. hours employees work more (max) or less (min) than scheduled) and a clear arrangement regarding the availability expected of workers on days they are not scheduled to work (CNV, 2021). As written before, the largest union FNV did not sign this sector agreement because it did not agree to the required flexibility of staff and the limited increases in wages.

Aside from the collective labour agreements, there is national regulation relevant for the wages and/or working conditions in the Dutch LTC and ECEC sectors. Due to the semi-public organisation of the Dutch LTC sector, wages are directly controlled by what is known as an 'OVA-system'. Moreover, this diverse sector has a system of financing depending on a complex combination of three pieces of legislation: the Long-Term Care Act [Wet langdurige zorg], the Care Insurance Act [Zorgverzekeringswet] and the Social Support Act [Wet maatschappelijke ondersteuning]. In contrast, the Dutch ECEC sector is privately organized, and wage-bargaining between unions and employers' organisation is more independent from public budgets. Nevertheless, there are several acts which directly impact the working conditions of pedagogical workers or childminders in the ECEC sector, the most important of which is the Innovation and Quality Childcare Act [Wet Innovatie en Kwaliteit Kinderopvang] |(see 2.1.3).

Three aspects of this law are relevant for the working conditions in the Dutch ECEC sector – and play a major role in the debate between social partners –:

1. The 'professional-child-ratio' or BKR [beroepskracht-kind ratio]. This article specifies the maximum number of children which can be served by one single pedagogical employee in a daycare organisation – which is set to 16 children.

2. The ‘three hours arrangement’ [drie-uurs regeling]. This rule states that organisations providing ECEC services in the Netherlands are allowed to deviate from the BKR for a maximum of three hours per day. This gives pedagogical staff the time to attend to other tasks – such as administration – as well as to take breaks.
3. The ‘familiair faces principle’ [vaste gezichten principe] ensures that any individual child is served by at most two different employees. This limit is there so that children are not exposed to too many different caretakers at an early age – possibly leading to negative consequences such as attachment issues.

Like in the Dutch LTC sector, the regulation of the collective labour agreement in the Dutch ECEC sector has been a point of concern for (some of) the social partners. For example, the previous collective labour agreement explicitly calls for the need to establish a ‘compliance hotline’ – via which employers and employees can report breaches of the agreement (AOK, 2019). Meanwhile, the ‘general’ agreement between the CNV and BK/BMK, currently pending its generally binding status, confirms the importance of this hotline and also specifies that the Dutch Municipal Health Services shall be made responsible for controlling compliance with specific regulations of the agreement, ‘such as the building, size of the groups, the employment of not enough staff or underqualified staff’ (AOK, 2021; 49).

In contrast, employers’ organisation BvoK opines that this article has made the collective labour agreement ‘unlawful’. It argues that the Municipal Health Services are not mandated to enforce the collective labour agreement, since this agreement falls under civil law and falls as such outside its jurisdiction. The mandate of the Municipal Health Services is limited to enforcing compliance with national and administrative legislation. This is one of the main arguments it uses to challenge the possibility that this ‘general’ collective labour agreement is made generally binding and thus ‘prevails’ over its own agreement with LBV.

4.1.2 Regulation of terms and conditions of employment in the Dutch LTC Sector

The currently effective collective labour agreement (2022-2023) is the follow-up of an extension of the collective labour agreement 2019-2021 – which covers around 460,000 employees in the sector. This extension was agreed upon by the social partners due to the currently uncertain political situation. The election result of the previous elections left the Dutch political landscape highly fragmented, leading to an unusually long formation period (de Leeuw & Muselaers, 2021; Hofstede, 2021). The current Dutch government was longtime in ‘demissionary’ status following its resignation due to a large public affair following, known in the Netherlands as the ‘child supplement affair’ [kindertoeslagaffaire] (NOS, 2021). Discussing this affair at length is beyond the scope of this research report. More to the point of this report are tripartite discussions on collective wage developments

in the heath and care sectors. In 2021 the Social-Economic Council (SER, 2021) reached consensus on a joint problem regarding the issue of wages. In short, while the trend in wages in the Dutch LTC sector more or less followed other care and market sectors, the wage level had been low at the start in earlier years and had remained low. Nowadays, the collective bargaining parties in the LTC sector follow the average wage developments in the private market, as a result of which the collective bargaining parties have become less dependent on the public budgets. However, the structural lagging behind of wage levels in care sectors that was caused in the past is still an issue among social partners in the LTC sector (SOVVT, 2021b). This section will detail the contents and main features of the collective labour agreement of 'nursing homes, homes for the elderly, homecare and youth care 2019-2021' [cao verpleeg-, verzorgingshuizen, thuiszorg en jeugdgezondheidszorg 2019-2021]. This labour agreement is generally binding for the sector and was signed by two employers' representatives (ActiZ and ZorgthuisNL). The employees are represented by two 'general' labour unions (FNV Zorg en Welzijn and CNV Zorg en Welzijn), as well as two professional organisations (Nu'91 and FBZ).

Regarding the collective labour agreement in the Dutch LTC sector, it deals with the following topics:

- ✓ Definitions and determination of the labour relations
- ✓ Wages and other financial benefits for workers
- ✓ Working hours and working times
- ✓ Work-life balance
- ✓ Options for terms of employment
- ✓ Health and safety regulations
- ✓ Definition and differentiation of labour positions
- ✓ Reorganisation
- ✓ 'Decentralized' (i.e. organisational-level) arrangements (SOVVT, 2019; 2-3)

Signifying the high degree of consensus regarding problem definition in this sector (more on that below), the collective labour agreement opens with national priorities of the social partners, where they agree to tackle several urgent issues regarding the working conditions in the LTC sector through a tripartite, national social dialogue. First, this includes the 'labour market agenda' to address the growing shortage of staff in the sector. Second, the social partners agreed to increase the number of permanent contracts as well as the working hours of employees. Finally, the partners agreed that the sustainable employability of staff urgently needs to be enhanced in connection with the challenging working conditions in the sector, indicated by a high working pressure and sick leave.
Moreover, the collective labour agreement is also used by the signatories to install a 'working group 'Human and Labour' which specifically focuses on enhancing the sustainable employment of staff in the sector by addressing four key issues: enhancing the assertiveness

of staff, improving or guarding the work-life balance, enhancing leadership or the autonomy of teams, and finally the continuous professional improvement of staff (SOVVT, 2021).

In 2022 the social partners agreed a new collective agreement in the LTC-sector. This includes a 6 percent collective increase of all the wages and a measure to combat the high workload of workers in the sector. For this purpose, people are no longer allowed to work more than 5 days in a week (unless they want to do so themselves) and may be 'unreachable' if they are not rostered for work.

The regulation of the terms and conditions of employment in the Dutch LTC Sector has historically been an issue of concern of the social partners. In fact, the collective labour agreement is used to install a 'Commission Compliance' [Commissie Naleving] – which is charged with evaluating compliance with the agreement by Dutch LTC organisations.

This compliance was especially low in the latter half of the first decade of the 21st century, when public procurement had just been introduced in Dutch home care – together with a decentralization of responsibilities for organizing home care and social work services to the municipalities and the introduction of austerity measures. This created a situation in which many municipalities opted for 'open house contracting' – in which they hardly made any selection in terms of providers and simply contracted the organisation with the lowest offer in terms of pricing.

Due to this decentralization and the introduction of public procurement, many traditional suppliers of home care services went bankrupt, leading to a large loss of jobs in the sector (estimated to be around 70,000 jobs). This 'gap' in the market – together with the open house style of contracting - led to the rise of so-called Care Cowboys [Zorgcowboys]. These are organisations which used all kinds of 'dirty tricks' – i.e. barely legal means – to cut costs, and which were notorious for not complying with labour regulations. For example, some organisations only employed 'alpha-helpers' [alfa-hulpen]. Alpha-helpers were intended as supportive staff for nurses and homecare staff, mostly worked part-time and did not build up any pensions. Of course, these 'alpha-helpers' were never intended to be the primary workforce, so organisations which relied almost exclusively on these helpers were simply trying to cut labour costs.

Alternatively, care cowboys employed cleaning staff – falling under the collective labour agreement for the cleaning sector with less favourable terms of employment – to do the work of homecare staff. This was possible because the tasks of these employees were increasingly reduced to 'simply cleaning' rather than providing 'mental and psychological support' to their clients, for example by engaging in small talk over a cup of coffee.

The rise of these Care Cowboys also fuelled a 'race to the bottom' in terms of working conditions. From the perspective of employees, each round of procurement effectively amounted to a worsening of their conditions and terms of employment. This motivated the social partners to amend the collective labour agreement in 2019 – stipulating that the working conditions of 'helpers' in home-based care should not deteriorate if they switched between employers.

4.2 Working conditions in the ECEC and LTC services

Having outlined the regulatory backgrounds for the terms of employment in both sectors in the previous section, we now turn to the working conditions in both sectors.

4.2.1 Working conditions in the Dutch ECEC sector

While the perspectives of the social partners on the working conditions in the Dutch LTC sector are relatively homogeneous, there are major disagreements between the social partners in the ECEC sector on what the working conditions are, and which factors are responsible for the current working conditions in the sector. However, before we discuss these perspectives on the working conditions in the sector, it is relevant to note that the workforce is – in general – composed of two groups of employees. First, the pedagogical staff that attends to the cognitive and emotional development of the children. These employees have completed secondary vocational training level 3 or 4. Second, there are also assistants known as childminders, who attend to the direct needs of children and support the pedagogical staff. Childminders are generally less highly educated than the pedagogical staff, having completed secondary vocational training level 2.

While the wages in the sector and the required flexibility of staff were dividing issues between the social partners – especially between the FNV on the one hand, and the CNV, BK and BMK on the other – most social partners agree that the pedagogical staff is exposed to unacceptable levels of working pressure. Moreover, they also agree on one of the causes of this working pressure: staff shortages in the sector. Surveys in 2022 show that 61 percent of the workers in childcare report a (far) too high workload. 78 percent of the workers report that this workload has been grown in the last year.22 Absence levels are at a high level of 10 percent medio 2022.23

The staff shortages amongst pedagogical staff are not so much due to a lack of inflow of workers from educational institutions, but rather to a relatively high outflow of employees. Many pedagogical staff seek jobs elsewhere, such as in primary education. One reason for

[22] Werkdruk en arbeidstevredenheid in de zorg (cbs.nl)
[23] In eerste kwartaal 2022 hoogste ziekteverzuim ooit gemeten (cbs.nl)

the relatively high outflow in the sector are the limited opportunities for professional development in the sector. This is partly due to the way in which the Dutch ECEC sector is organized, consisting largely of small and 'flat' organisations. Other reasons for this outflow of employees that most (not all) social partners agree on are the working pressure and the lack of autonomy pedagogical that staff experience in carrying out their duties.

This working pressure has increased due to -and is still influenced by - the Innovation and Quality Childcare act, which provides that pedagogical staff must constantly analyse and report on the cognitive and emotional development of children. The three aspects of this act – i.e. the 'BKR', the three-hours arrangement and the familiar faces principles – are the most problematic aspects mentioned by the social partners. To start with, both employers' organisations and unions feel that the 'three hours principle' is impracticle in light of the current staff shortages. Pedagogical staff simply cannot be missed for three whole hours on a day, which often means they have to do administrative tasks while attending the group of children. Moreover, both unions and employers' organisation consider the BKR to be too rigid, but for different reasons. For a union like the FNV this means that the BKR assigns too many children (16) to a single professional, and employers should take more into account that the BKR assigns a maximum rather than a desirable number of children to each professional. Meanwhile, employers' organisation BK opines that the problem with the BKR is that it is based on age. When a child goes from zero to one year of age, this means that from one day to the next you need more personnel in your organisation – which is not always feasible.

According to the FNV, the feedback loop between working pressure and staff shortages is exacerbated by the private organisation of the Dutch ECEC sector. First, employers focus on serving as many children as possible, because each child adds to their bottom line. As a result, profit-driven ECEC organisations constantly push the limits of the BKR (see above). Secondly, this union notes an 'expansion' in the services 'being promised to parents'. Instead of focusing on their core tasks, pedagogical staff are increasingly required to take up additional duties to make the daycare 'more fun' for parents. This includes activities such as taking 'cute' pictures or otherwise recording the 'funny' things children at young ages say or do. The unions feels that these tasks are better left to childminders, but they find that organisations are unwilling to hire additional supporting staff. Meanwhile, employers' organisation BK stresses that additional staff is not always the solution to working pressure problems.

As stated, most social partners agree that working pressure is an issue and that it is related to the regulatory pressure resulting from the Innovation and Quality Childcare Act. However, employers' organisations BvoK feels that 'this problem is invented by FNV' simply to justify the strikes and actions they are organizing at the time of research and writing (more on this below). Rather, this organisation feels that 'a scientific view' on the working

conditions in the sector should not focus on working pressure, but rather on 'working fun' – i.e. the intrinsic motivation employees feel to do their best for the children. To substantiate this allegation, the agreement they reached with the LBV lists a wide range of factors that supposedly contribute to working fun, including the work's meaningful nature, its challenging character and the possibilities for growth as well as its predictability and safety (BvoK, LBV, 2021).

Finally, whether or not the required flexibility of staff is at an acceptable level is a contested issue within the sector. On the one hand, the FNV argues that too much flexibility is required of staff. First, much like in the LTC sector, the 'yearly planning systematics' [jaarurensystematiek] is an important contributor to the working pressure in the sector. It has the effect that employees are uncertain about the actual number of hours they can work and the hours they actually get paid. Second, and more specific to the ECEC sector, the 'availability day' [beschikbaarheidsdag] has the effect that employees can be called to work even on days they are not scheduled. On the other hand, the employer organisations BK and BMK – as well as the labour union CNV – feel that the required flexibility of staff is reasonable. They stress that the 'horror stories told by the FNV' – in which employees were called in the morning and expected to show up at work in the afternoon – are not so much due to how the rules are, but rather to how the rules are applied by employees. For example, employees can only be called upon for their 'availability day' at two weeks' notice. That is why in the collective agreement signed by these parties the 'availability day' is still there, but is 'explained better' and renamed the non-scheduled day to remove any negative associations with the term availability day'.

4.2.2 Working conditions in the Dutch LTC sector

"*The 'white rage' is coming quite close once again. Many people leave and work somewhere else out of frustration. [..] The true appreciation [of care professionals] is simply not there!'* – negotiator Nu'91

The 'white rage' was an era of social protest among workers in the Dutch care sector ('white' is referring to the white coloured uniforms of the nurses and other care professionals). The quotation above sharply illustrates how challenging the current working conditions are for care professionals in the Dutch LTC sector. Of course, it makes sense that a negotiator of a professional organisation and union (Nu'91 – more below) would express the frustrations of staff. However, there is an overwhelming consensus between the social partners and government when it comes to the recognition and identification of problems concerning working conditions. The information below largely reflects this consensus. Still, some difference of opinion remains about the cause of these issues and how they can best be addressed.

To start with, the wages in the Dutch LTC sector are particularly low. A recent report by the Social-Economic Council (2021) – in which both union representatives, as well as representatives of employers' organisations, relevant ministries and scientific institutions take part - acknowledges that the wages in the Dutch LTC sector have lagged behind wages in other public sectors by a gap of 6%, and by 9% compared to wages in market sectors. This gap is due to the way in which the 'Government contribution in the labour costs development of the care sector' (OVA) [Overheidsbijdrage in de Arbeidskostenontwikkeling zorg] is calculated. The OVA ensured that wages in the sector increased alongside wages in other public sectors. However, the start level of the remuneration was too low, due to its initial calibration, and the level has remained low ever since.

Secondly, the working pressure in the sector is quite high – with significant effects on the physical and mental health of staff members. Care professionals have less and less time for the same tasks (SER, 2021). This increase in workloads is due to a complex combination of developments. First, the 'double ageing' of the population. On the one hand, the ageing of the general Dutch population means that there less and less people are available to fill care jobs. On the other, the ageing population means an increased demand for care services (ibid., 22). Secondly, the working pressure is exacerbated by a shortage of staff. The staff shortage in the Dutch LTC sector is due to the combination of a high outflow and a low inflow of employees. Reverse causation is at play here, since this combination is itself (partly) caused by the increase in working pressure. At the same time, the difficulties of attracting workers on the one hand and retaining them on the other have separate contributing factors relating to low wages (see above), limited career opportunities, as well as regulatory pressure and professional autonomy.

Third, as mentioned, working in the Dutch LTC sector is characterized by high regulatory pressure combined with low professional autonomy. This expresses itself in different ways in the public subsectors (nursing homes, home nursing) and semi-public/private subsectors (home care). For nurses, their tasks are defined quite strictly through a system of 'profiles of care' designed by the Ministry of Health, Welfare, and Sports. These profiles are applied to specific clients by the care agencies, in dialogue with the general practitioner or doctor, as well as the home nurses. Each profile comes with a specific list of tasks and designated 'care hours'. But care professionals 'repeatedly bump against the rigidity of the system' – for example when the situation of client worsens more gradually or acutely than the system can process (FNV negotiator LTC sector).

Meanwhile, home caregivers are limited in the way they can care for their clients due to the organisation of this sector through public procurement at the municipal level. Since care services must be bought by municipalities, each 'care task' must be a 'specific product' (i.e. specific tasks) with 'specific costs' (in terms of time and pay) – the parameters of which are agreed upon by municipalities and contractors. Moreover, since care services are organized

at the municipal level, each municipality has its own lists of products and there has been a fragmentation in rules and governance of the home care sector. In addition, the 'decentralization' of home care (as well as youth care and social work) coincided with austerity measures. As a result, municipalities have to attend more responsibilities with less resources – creating a strong incentive to select care organisations simply based on the lowest price. As mentioned, this has led to the rise of 'care cowboys'.

There is wide consensus on the challenges of municipalities in providing care services and the existence of 'care cowboys'. In contrast, there is difference of opinion about the role of the practices of public procurement in increasing the regulatory pressure on staff. Unions and employer organisations generally agree that the decentralization of LTC services and the introduction of public procurement, especially in combination with austerity measures, has increased the working pressure and limited the autonomy of staff. In fact, the largest union in the sector, FNV Zorg & Welzijn has written a letter jointly with the smaller employers' organisation Zorgthuisnl to the Ministry of Health, Welfare and Sport at the 12th of May 2021 to address this very issue (de Haas & Buijing, 2021). Yet, the largest employers' organisation – ActiZ – is not against public procurement in principle. Its criticisms of this system is limited to the complex system of narrowly defined 'care products' – designed by municipalities that have little understanding of how these services should be provided in practice.

Fourthly, social partners and government agree that the opportunities for skill and career development are limited in the Dutch LTC sector. Getting sufficient people qualified to provide the needed care in an efficient manner is a big and growing challenge due to the increasing complexity and the size of the demand for care (SER, 2021). Regarding skill development, there have been some initiatives on 'partial certificates', which would allow people to qualify for certain specific tasks, rather than become a fully licensed professional with a full degree based on a full curriculum. These initiatives were especially urgent due to the Corona-crisis, which sharply increased the demand for care professionals. For example, the social partners at the national care and education sectors collaborated – on the initiative of employers' organisation ActiZ - to create a 'National Care-class'. This initiative provides three-days of online training, enabling people to quickly become an 'assistant caregiver' (Nationale Zorgklas, 2021). However, there is a big difference within the sector in the possibilities for such initiatives. Nurses or 'caregivers' who work 'intramural' within care organisations have plenty opportunities for direct supervision and assistance because they work in larger teams. Meanwhile, employees in homecare or home nursing usually work alone –only in exceptional circumstances with one or two colleagues. This limits the opportunities for providing assistance and supervision, and thus hinders the skill development of new entrants in the workforce.

Finally, the required flexibility of staff in terms of working hours and planning are an issue raised by the unions, but their analysis is not shared by the employers' organisations or government. In fact, addressing the 'permanent availability' required of staff due to the application of the 'system of yearly planning' [jaarurensystematiek] is a 'spearpoint' of the 'general' and largest union in the sector FNV Zorg & Welzijn. In contrast, employer organisations – such as the largest organisation ActiZ – emphasize that LTC organisations need to be able to supply clients with the right care '24 hours a day, 7 hours a week'. Nevertheless, ActiZ encourages its members to organize the required flexibility with the least possible pressure on staff. In line with this, the FNV recognizes that the flexibility issue is best addressed at the level of organisations, rather than at the sectoral or national social dialogue. While 'some aspects' can be arranged through the collective labour agreement (see the recent collective agreement, section 4.1.1., and see more below), this system is part of the entire planning strategy of organisations. Thus, this issue is best addressed through the works councils – which are supported by the FNV.

Chapter 5: The actors of the employment relations in the ECEC and LTC services in the Netherlands

Social dialogue in the welfare sectors in the Netherlands can be characterized as a game of chess on two boards – each with different players at the table. On the one hand, there is the tripartite national level of social dialogue. Here, representatives of workers (1/3), employers (1/3) and experts appointed by 'the crown' (mostly from the academic community) have their seats in the Socio-Economic Council or 'SER' [Sociaal-Economische Raad]. The SER advises the government about the governance of the healthcare sector – including its labour market - and how it might be adapted in the context of financial, social and qualitative sustainability. On the other hand, employers' organisations and unions engage in sectoral collective bargaining without involvement from the government. Nevertheless, several ministries are (indirectly) involved with the unions and employers' organisations. On the one hand, the ministry of Social Affairs and Employment is required to formally declare the collective labour agreement arrived at between employers' organisations and unions generally binding (i.e. binding for organisations that are not a member of employers' organisations, and employees who are not a member of a union). On the other hand, sectoral employers' organisations and unions have regular informal meetings and negotiations with relevant ministries. For the Dutch LTC sector, this kind of lobbying by social partners is directed at the ministry of Health, Welfare and Sport while for the ECEC sector lobbying activities target the ministry of Social Affairs and Employment. These lobby activities towards Ministries – and also to Parliament members - can have influence on care policies.

Although the Socio-Economic Council is formally one single body, in practice it works through numerous commissions – some more temporary and others more permanent in nature. Representatives of the unions and employers' organisations participate in these commissions, and they are joined by appointed independent experts. The reports made by these commissions reflect the consensus between social partners. Just before the covid-19 pandemic, the SER published a report about the 'future proofing of care provision' (SER, 2020). This report came to four general conclusions in the triangular challenge of securing access to care, quality of care and financial affordability. Firstly, achieving a balance between care that is collectively insured for all and care that can be financed at a more individual level. Secondly, its focus on prevention and care in other domains than the healthcare sector (such as school, neighbourhoods, work). Thirdly, more digital investments in care organisations and care provisions. Finally, a system that is more based on professionalism and autonomy of care workers. In 2022 the 'Commission labour market social sectors' (Commissie Arbeidsproblematiek maatschappelijke sectoren'), asked for political actions to combat labour scarcity in public sectors like education and care (SER, 2022). The COVID-19 pandemic has increased the sense of urgency in society about the importance – and vulnerability – of social sectors like care and education. Expectations are that there 135,000 (!) extra workers will be needed in the care sectors in 2031. Most problems are expected among nurses and other care professionals in elderly care. Recommendations in this report points to expanding hours of part-time workers (in addition to new labour market entrants and pensioners), higher quality of work, technological and social innovation, combating 'red tape' and long term perspectives in policy and financing (SER, 2022) These recommendations are similar to those mentioned a year before for only the care sectors (SER, 2021).

5.1 Presentation of main actors, characteristics, relevance in the employment relations system and power

5.1.1 Main actors in the Dutch ECEC sector

Employers

Until recently, employers in this sector were represented by two organisations: Brancheorganisatie Kinderopvang (BK) and Brancheorganisatie Maatschappelijke Kinderopvang (BMK). However, this round of collective bargaining they were joined by a new player in the field: the BrancheVereniging voor Ondernemers in the Kinderopvang (BvoK). Employees in the sector are represented by two subsidiaries of the traditional and general unions FNV and CNV: FNV Zorg & Welzijn and CNV Zorg & Welzijn. While the LBV is a party to the collective labour agreement with the BvoK, it is not considered to represented the interests of workers – due to its status as a 'yellow union' (see section 4.1.2).

The BK is – in its own words - 'closely aligned' with the BMK. Together, they represent around 75% of the employment in the Dutch ECEC sector. In fact, the organisations are so close that they submit a 'joint letter of demands' when they start the collective labour negotiations. Still, there is a key difference in the constituency of these organisations. Where the BMK mostly represents not-for-profit organisations, the BK has a 'broad constituency' representing both foundations and commercial enterprises. Moreover, the size of these organisations varies greatly, from small- to medium sized enterprises to 'large organisations with millions of revenue'. To deal with diversity in the agenda setting process for sectoral bargaining, the members vote on issues to be addressed by the organisations. The voting weight of each member is based on its turnover: the more turnover an organisation has, the more voting power it has.

The priorities of the BK in sectoral bargaining are twofold. First, to improve the 'image' of the pedagogical employees. The regulatory pressure they experience is an indicator that they are not taken seriously as autonomous professionals. Second, to 'empower' employees to take 'their own responsibility for their own development'. This means that the costs of training and courses should in large part fall on the shoulders of employees themselves – as it is an investment in human capital. This organisation strives to achieve that employers facilitate the professional development of their staff by giving them time, while the financial costs should be bore by employees. Yet, the BK feels the largest issue in the sector – the working pressure and staff shortages – cannot be tackled at the sectoral level. The regulatory pressure mostly comes from regulations such as the Innovation and Quality Childcare Act – which must addressed at the national level of tripartite social dialogue rather than at the sectoral level.

The BMK emerged as 'an offshoot' of the BK around five years ago (around 2015). This split occurred at the time when the Dutch ECEC organisations were give more pedagogical and educational tasks: such as organizing the pre- and early school education of children who lag behind their peers in cognitive or emotional development. As mentioned, the BMK mostly represents non-profit foundations – which are also relatively small compared to the for-profit enterprises represented by BK. In total, they have around 95 members. There is a 'small overlap' in the membership of BMK and BK. These are organisations 'which do not agree with a fractured representation of employers side in social dialogue'. Some of these members feel that the BMK and BK should merge. Thus, while both parties together have a 'coverage of around 75%', there is about '5% overlap in membership'.

Whereas the BK stresses its intimate connection with BMK, BMK itself tends to stress their differences. In fact, in the first round of negotiations BMK participated in – it often felt more aligned with the unions rather than the other employers'organisation. This because – unlike the more commercially oriented BK – it focuses very much on the interests of the children and the social value of the ECEC sector. In its own words, the priorities of BMK lie

with ‘the qualitative aspects’ of the ECEC sector – which are currently threefold. First, it focuses on acquiring sufficient ‘non-group bound hours’ of staff. The organisation points to primary education, where there is a ‘solid agreement’ that staff ‘can spend 40% of their time on administrative matters’. Second, it would like to see more differentiation in functions, especially when it comes to the pedagogical staff. This way, there can be more opportunities for professional development in an otherwise quite immobile sector. Finally, - and here lies a sharp contrast with BK – the BMK would like employers to invest more in the ‘life long development’ of their staff.

The BMK notes that its participation has shifted the position of the BK to the ‘more social rather than commercial side’. For example, they finally agreed that staff members should be compensated for the time they put in professional and personal development. This shift does not reflect some ideology, but is rather a matter of strategy. When BMK just joined, both employer organisations were ‘set up against one another’ by the unions, making both lose influence. So it soon became clear that the two employers’ organisations should collaborate. However, it took a while before ‘both parties learned to give each other enough space to deviate from the common ground’. Early attempts of both employers organisations to ‘speak as one’ failed, because ‘the BK represented only the interests of employers, while the BMK represented the interests of children’. The ‘joint letter of themes’ the employers’ organisations were able to submit this round was the first successful collaboration of both parties.

In sharp contrast to the other two employers’ organisations, the BvoK mostly represents (very) small to medium sized enterprises – most of them having no more than ten employees. This organisation sees itself as the ‘lone hero’ for these small and ‘micro-sized’ organisations in the Dutch ECEC sector. This because a large part of these small enterprises are ‘unorganized’, and this organisation is ‘the only one’ which – somewhat paradoxically – aims to formally represent the interests of these unorganized organisations.

Although both BK and BMK have (some) smaller organisations amongst their members, the BvoK feels that these employers’ organisations are unfit to represent their interests due to the overpower influence of larger organisations within these representative institutions. To illustrate the power differential between the larger and smaller organisations, the BvoK notes that ‘4% of the largest employers employ almost 50% of the employees [..] which is also an indication of their turnover’. Therefore, the voting power of the members of this organisation is explicitly not based on their turnover –each member simply has a single vote.

The priorities of this organisation are not aimed at the sectoral social dialogue, as this organisation feels that it is precisely the sectoral organisation of the social dialogue that hurts the interests of its members (see section 5.2). Still, the key issues brought forward by the BvoK before they withdrew from the negotiations with the other unions and employer

organisations were twofold. First, it is against the regulation in the current (and previous) collective agreement that all organisations need to have a works council. As the representative opines: “That even small- and medium sized enterprises need to have a works council is not the case anywhere else. This extralegal rule is only present in the childcare sector.” In contrast, the organisation feels that such formal relations between employers and employees do not match the real practice, where contact between workers and their employers is based on daily, personal contact. Secondly, and for the same reason, the BvoK is against the ‘availability day’ and the ‘yearly planning schematics’. These tools are too formal to organize labour in small organisations. At first glance, it may seem that this standpoint makes them (unlikely) allies of FNV Zorg & Welzijn – which is also against these two measures. However, these standpoints are based on a diametrically opposed view on the working conditions in the sector (see section 4.2).

Despite their large ideological differences, the BMK stresses that the ‘participation of the BvoK is also positive’. In particular, it creates a more inclusive dialogue in which ‘more perspectives come to the fore, including those of small- and medium sized enterprises’. In addition, the arguments put forward by the BvoK also increase the need for unions to defend their positions more strongly. Thus all in all leading to an increase in the number and quality of the arguments exchanged at the table.

Trade unions

Much like in the Dutch LTC sector, the employees in the Dutch ECEC sector are represented by the FNV Zorg & Welzijn and CNV Zorg & Welzijn. Still, the strategic positioning of these organisations is varies from sector to sector. Starting with FNV Zorg & Welzijn, its coverage in the childcare sector is ‘relatively low’ – estimated to cover around 14,000 of the 108,000 employees in the sector (roughly 14%). Around 90 to 95%’ of its members are pedagogical employees, rather than childminders or other assistants. Moreover, many of its members are former employees of pre- or early school educational institutions who were transferred to the childcare sector when these services were merged together. These employees ‘are used to better terms and conditions of employment’ as they used to fall under the collective agreement of social work, rather than childcare. There, they used to ‘have more designated time for administrative work’ and could focus on their core professional competencies.

Before the FNV withdrew from the sectoral negotiations in the Dutch ECEC sector, its priorities were twofold: addressing the low (financial) valuation of staff and the high flexibility required of workers. These issues were addressed in four ways: removing the ‘yearly planning schematics’, removing the ‘availability day’, enabling the attraction of more childminders to support the pedagogical staff at childcare organisations, and finally increasing the pay of workers in the sector by 5% on average. During the negotiations, the demands for increase in pay were seen as a bargaining chip the FNV was willing to trade in return for decreases in working pressure.

5.1.2 Main actors in the Dutch LTC sector

Two main actors represent the employers in this sector: ActiZ and Zorgthuisnl. In addition, there are two subsidiaries of the two 'general' unions active in this sector, being FNV Zorg en Welzijn. And CNV Zorg en Welzijn (transl.: FNV/CNV Care and Wellbeing). Finally, employees are also represented by two professional associations which act as unions: Nu'91 and FBZ. We present these actors in turn.

Employers

ActiZ is a federation representing a 'diverse group' of employers in the LTC sector. For example, there is a unit of home nursing organisations, a unit of youth care organisations and so on. Each unit has its own board. 'Above' these boards are six 'sub-boards' [deelbesturen] which are organized thematically. They govern themes like digitalization or governance. The organisation was set up like a federation to facilitate active participation of a large proportion of its members in the agenda-setting and decision-making process. So far, it seems to work, as around 100 of their 400 members are actively participating in the governance of the organisation.

The coverage of ActiZ varies sharply for each subsector in the Dutch LTC sector. While their coverage 'is around 99%' when it comes to the nursing homes and 'alternative living arrangements'. This subsector is mainly composed of small- and medium-sized enterprises, although there are 'a handful' of larger organisations. Meanwhile, their coverage in home nursing is 'only 60%' and in youth care even 50%. Their relatively low coverage in the youth care sector is partly explained by the fact that youth care services are mainly provided by the Municipal Health Services.

The main priorities of ActiZ in social dialogue are threefold. First, the sustainable employability of staff in the LTC sector. This is a key issue given the ageing population, which ageing entails that the demand for care services increases and becomes more complex, while these services have to be provided by a smaller segment of the population. Second, this organisation focuses on enhancing the opportunities for professional development of employees in the LTC sector. This professionalisation is not only necessary in connection with the aforementioned increasing complexity of care services, but is also a means to foster the inflow of new personnel (and hence combat the staff shortages). For example, ActiZ works with educational institutions to create certificates for specific tasks, so that students can start working earlier in their educational career, rather than having to first obtain a full degree covering an entire curriculum. However, this priority is much harder to achieve in extramural care (e.g. homecare and -nursing) compared to intramural care (e.g. nursing homes). This because personnel in extramural care work independently, and

opportunities for supervision are extremely limited without doubling one's labour costs. Thirdly, ActiZ strives to make sure that employers have enough flexibility to provide clients with the right care '24 hours a day, 7 days a week'. On the one hand, this requires keeping the collective labour agreement 'streamlined'. This entails curbing the 'tendency of unions like the FNV' of formulating 'too many' conditions and demands – such as a maximum length of shifts, or a maximum number of 'cut-up' shifts. On the other hand, Actiz encourages its members to organize the required flexibility 'with as little pressure on staff as possible'.

Zorgthuisnl is an employers' organisation set up in 1997 as a 'counterweight' to its 'big brother' ActiZ. It represents around 200 organisations, mostly small- and medium sized commercial enterprises providing extramural care (i.e. home care). This in contrast to the larger and not-for-profit nursing homes etc. represented by ActiZ. The members of Zorgthuisnl 'used to have a reputation of being care cowboys', but according to this organisation, this is simply because the vested interests did not want to welcome a group of 'new and innovative' players in the field of LTC services. This organisation stands for the professionalism of its members, stressing that many of these small enterprises were set up by people who used to work in this sector and 'who feel there is room for improvement' in how services are organised.

Zorgthuisnl is organized as a 'network organisation' in which members can influence the agenda – including the priorities in collective bargaining – through national 'discussion tables' (Zorgthuisnl, 2021a). One of the most important priorities of this organisation in the social dialogue is combating the staff shortages by fostering the inflow of new employees. As stated above, arranging supervision of interns or starters on the job market is particularly challenging in extramural care. This is in large part due to the way home care is financed, which 'makes it unthinkable that more than one professional provides care to a single client'. This issue lies outside the scope of the collective labour agreement, and Zorgthuisnl attempts to address this issue in the tripartite national social dialogue (more on this later). Nevertheless, Zorgthuisnl stresses that this issue can also be addressed at the sectoral level. Importantly, the function profiles on the lower end of the scale set 'too high educational requirements' and are too rigidly defined in the tasks they are allowed or not allowed to do. For example, 'helpers' must have a full secondary vocational training degree (level 2) but are not allowed to perform any medical tasks. This leads to absurd situations where helpers are allowed to cook food and give it to the client, but not allowed to help a client who struggles with eating it. According to the organisation, this 'job carving' has gone too far.

Trade unions

FNV Zorg & Welzijn is a subsidiary of the 'general' and largest union of the Netherlands, the FNV. Its main agenda-setting body is the 'sector advisory board' [Branche Advies Raad] which is a representative body of workers in the LTC sector. As regards its coverage, FNV

Zorg & Welzijn organizes around 9.3% of workers in this sector, totalling around 40,000 members. As is more generally the case with the membership of the FNV, it is mainly composed of the older segments of workers.

The key issues addressed by the FNV in the social dialogue in the LTC sector reflect the priorities of the union more generally: increasing the wages of workers by 5% across the board (but especially those at the lower end of the scale) and decreasing the required flexibility of workers. To achieve this first aim, the FNV is an adamant supporter of a nominal rather than a percentual increase of wages in the sector – especially the minimumwage. This would create a (desirable) levelling effect on the wages in the sector.

Secondly, according to the FNV Zorg & Welzijn, the flexibility required of workers in the LTC sector amounts to 'permanent availability' since care must be organized 24/7 and employees are expected to be ready to serve their clients at all times. Instead of working 8 hours a day for a few days a week, this unions notes that employees are expected to work an increasing number of ever-shorter shifts. For example, they note a case of an LTC worker who started out with 4 shifts of 6 hours of work, but these shifts were increasingly cut up to 6 shifts of 4 hours and eventually 12 shifts of 2 hours. This 'permanent availability' makes it hard to combine work with a private life. This problem is exacerbated because the majority of workers in this sector are women, who have more caretaking duties at home compared to men. To combat this issue, the FNV Zorg & Welzijn aims to abolish the 'yearly planning system' [jaarurensystematiek] (see section 4.1.2).

CNV Zorg & Welzijn is a part of a multi-tiered federative structure. CNV Zorg & Welzijn is a subsidiary of CNV Connectief, which in turn is a part of the larger CNV. The CNV is a general union – like the FNV – which has survived the 'depillarization' in the Netherlands in the 1960s. It is the Christian and more 'moderate' counterpart of the socialist FNV (de Beer & Keune, 2017).

Nu'91 is a professional organisation for nurses, which also acts as a union in this sector. It emerged from the 'white rage' of the early 90s: a series of protests and strikes by nurses and other care staff who felt they were not properly valued for their services. To be very clear, the 'whiteness' of this rage refers to the white uniforms of the nursing staff, rather than having any racist implications. Of their total membership of roughly 40,000 nurses, 6,500 of them work in the LTC sector (amounting to roughly 16% of their constituency).

Since it is a professional organisation as well as a trade union, Nu'91 sees a contrast with a more 'general' union like the FNV. It represents the specific interests of a category of workers within the sector, rather than all employees within the sector. This 'categorical organisation' gives them the ability to focus on the interests specific to this group. Moreover, it also has the effect that it not only focuses on improving the working conditions

and terms of employment, but also on the 'content' of the work: which tasks personnel has to carry out in what ways.

This specific constituency enables this organisation to focus on issues it considers overlooked by other social partners. In particular, the low wages of nurses, in particular relative to other care staff, as well as the high working pressure and lack of autonomy experienced by this group of workers. It criticizes the 'general' approach of the FNV and CNV on two fronts. First, their focus on 'increasingly general' rules. In contrast, Nu'91 feels that the terms of employment should be specific to the position and situation of specific subcategories of workers (such as nurses and caretakers) rather than generally applicable to all workers within a sector. For example, the focus of the FNV on a general increase of wages by 5% across the board as well as on demanding a standard 8-hour working day are considered inappropriate and undesirable for nurses and caretakers in particular. In contrast, this organisation emphasizes that many nurses and caretakers specifically choose to work in this sector because of the flexible working arrangements, making it easy to combine work and private life. Secondly, this organisation sees itself as 'more consensus oriented' than the 'traditional unions'. It looks for the 'common interests' between employees and employers, rather than conflicts of interests.

The FBZ is a federation of a large number of professional organisations. It mostly represents the higher segments of employees in the Dutch LTC sector, such as those active in scientific research.

5.2 Roles played by the actors, organisational dilemma's and strategies

The quality of social dialogue and collective bargaining is experienced quite differently in each sector by the social partners present. The negotiations in the Dutch LTC sector are characterized as productive, based on cooperative relations between social partners. In contrast, the negotiations in the ECEC sector have escalated, and are characterized by highly conflictual relations between parties (especially the FNV Zorg & Welzijn and the BvoK). In this section, a more cooperative attitude of parties in negotiations is understood as having more equal concern for the interests of the other as well as oneself (i.e. the shared interests), while a more conflictual attitude is characterized by a stronger focus on one's own interests as opposed to the interests of the other (i.e. conflicting interests) (Sorenson, Morse, & Savage, 1999; Rahim & Magner, 1995).

Despite the sharp differences between the dynamics in social dialogue in each sector, two more general insights are gained from the comparative discussion below. First, the importance of interpersonal relations within social dialogue. The negotiations in the LTC sector were 'very tense' until a few years ago, when the FNV has had 'some personnel changes, both in negotiators as well as in management'. These new negotiators were more

consensus-seeking and cooperative. Meanwhile, the relationship between the otherwise close parties of FNV and CNV in the Dutch ECEC sector have 'broken down' following the decision of the latter to accept the 'final offer' made by the employers' organisations. The negotiators have not have had any personal contact since this event. As noted by the negotiator: "How can we get back on speaking terms? I am also there as a person and… I don't know." Second, the social dialogue in both sectors can be characterized as a 'two-level game' (Putnam, 1988), where parties can follow two different strategies on each of the metaphorical chessboards. In particular, the FNV tends to combine a more profiling role towards its rank-and-file ('logic of membership') in collective bargaining at the sectoral level with a more consensus-seeking 'logic of influence' at the tripartite national level of social dialogue (Schmitter & Streeck, 1981).

5.2.1 Social dialogue in the Dutch ECEC sector

Collective bargaining in the Dutch ECEC sector has not witnessed the innovations seen in the LTC sector. Therefore, negotiations still follow the 'traditional' approach whereby parties send each other a 'letter of demands' with which they start the negotiations. Moreover, the last rounds of negotiations were described as especially challenging and arduous by the social partners. First, this is – according to CNV, BK and BMK – due to the 'activist' attitude of the FNV at the sectoral level of negotiations. Second, the entry of the BvoK has complicated the negotiations. Finally, the 'Corona situation' made it difficult to smooth out differences and have a nuanced discussion.

Starting with the FNV Zorg & Welzijn in particular, the BK notes that the FNV 'was not willing to make any agreement whatsoever'. The negotiator of the BK deduces this from the 'unrealistic demands' made by this union. For example, their insistence on having less children in each group than prescribed by the BKR is seen as one such unrealistic demand. Having smaller groups would mean that organisation require more staff to attend the same number of children, which is untenable in light of current staff shortages. In contrast, the FNV would suggest that employers need to reduce the number of children they accept if they do not have the staff to properly attend to their needs.

There were talks between the parties until March/April of 2021. The working pressure and wages in the sector were a 'constantly dividing issue' between the unions on the one hand, and the employers on the other. The negotiations escalated when the BK and BMK made a joint 'final offer' to the unions. While, the CNV did find this offer 'acceptable', the FNV did not – after which 'a lack of communication' divided both parties. The FNV framed the offer negatively in the general assembly, successfully realizing a formal rejection of this offer by its members. Meanwhile, the CNV presented the offer 'neutrally' to its members, which accepted it with a support of 70% amongst its voting members. The CNV 'gave a deadline' to

the FNV to ‘also agree’ or they would sign the agreement on their own. Following this ‘dagger in the back’, the FNV started organizing national actions and strikes right away.

The strikes organized by the FNV are condemned by the employers’ organisations (both BK, BMK as well as BvoK). Rather, these parties feel that these strikes ‘are simply a public relations stunt’ to attract more members. They are strengthened in this interpretation due to the contrast between the activist attitude of the FNV at this level of negotiations with its consensus-seeking approach in the Social-Economic Council and in the lobbying activities directed at the Ministry of Social Affairs and Employment. They stress that ‘only 2% of employees took part in these actions’ and that most staff members ‘do not recognize’ the concerns addressed by the FNV (the wages and required flexibility in particular). Going even further, the BvoK thinks the actions of the FNV are ‘irresponsible’. By casting the sector in a negative light, the FNV hinders the inflow and enhances the outflow of employees – which only worsens current staff shortages.

Moving on to the BvoK, the other social partners felt that its ‘lack of experience’ clearly showed during the negotiations. The BK experienced them as ‘an unstable partner’, explaining that ‘they said “Yes” to everything, and there were a lot of personnel changes – both in terms of negotiators but also in the board’. Moreover, the BK disliked that this fellow employers’ representative ‘tried to seek out the edges of the permissible’. This suspicion when the BvoK ‘left the negotiation table at the very last minute to sign an agreement with the LBV’.

Before removing itself from the negotiations, the BvoK also submitted a ‘final offer’ at the same time than the BK and BMK. Much to the chagrin of this organisation, the FNV did not even consider submitting this offer to its members. The BvoK considered this quite unreasonable, precisely because they are also against the ‘availability day’ and the ‘yearly planning scheme’ – just like the FNV. Following this, the BvoK felt that they ‘were not taken seriously’ by any of the other social partners and ‘actively sought’ an alternative union to close an agreement with.

This situation has created a interdependency between these two very opposing parties. The BvoK has signed a collective labour agreement with the LBV, and actively fights the intention of the Ministry of Social Affairs and Employment to declare the agreement between the CNV and BK/BMK as generally binding. Meanwhile, the FNV is only able to organise strikes and actions so long as this general collective agreement has not been declared binding. This interdependence is tense, precisely because these organisations are ideologically very much opposed to each other. In fact, the FNV feels that actors like the BvoK facilitate a ‘race to the bottom’ when it comes to terms and conditions of employment by seeking out ‘yellow unions’ to sign agreements with.

Despite the tense situation at the sectoral level, the BK/BMK and the FNV are 'on speaking terms at the political level'. For example, unions and employers' organisations held regular – weekly or bi-weekly – meetings with the Ministry to discuss 'Corona related issues'. Moreover, there are joints efforts to lobby for changes in the Innovation and Quality Childcare Act. In their talks with the Ministry of Health, Welfare and Sports, the current secretary of state has also recognized that this Act does not pay sufficient attention to the labour conditions. For example, he noted that the 'two familiar faces principle' could be amended, and that 'three faces would also be realistic and acceptable'. However, the secretary has a 'hands-off' approach when it comes to sectoral collective bargaining. While the employers organisations feel strengthened in their conviction that the collective labour agreement 'is not the problem', the FNV thinks this hands-off approach means that is it up to the bilateral social partners to anticipate these changes within the collective labour agreement.

The trilateral talks at the political level are mostly about amending the regulations which are relevant to employers and employees in the ECEC sector. This in contrast to the LTC sector, where the informal political lobbying of the social partners was very much about finances. This is due to the private organisation of the Dutch ECEC sector, which is mostly financed by parents rather than the government.

As a final note, the social partners in the ECEC sector stressed that 'the Corona situation' has complicated these already difficult negotiations. The meetings were exclusively held online. This was a demand more so of the unions than the employers, who preferred to meet offline. Their online character has made the negotiations 'shallow', making it so that the parties were only capable of 'simple compromises' to complex issues. One example of such a 'simple compromise' reached by BK/BMK and the CNV is on the distribution of financial and temporal costs of professional development tracks in the ECEC sector. This refers to the agreement that employer's compensate the time employees need to complete educational programs and courses, while they are financed by the employees themselves. This is an issue these parties would like to discuss in more detail 'when offline negotiations are possible again'.

5.2.2 Social dialogue in the Dutch LTC sector

All signatories to the collective labour agreement in the Dutch LTC sector characterize labour relations as productive. This is mainly due to a shared problem definition and sense of urgency (see section 4.2.1).

The relations between parties used to be more tense, especially in the era between 2014 and 2018 – when the FNV was seen as overly activist. For example, the negotiator of ActiZ

characterizes this period as ‘a time of agitation and propaganda’. According to the employers’ organisations, the FNV changed its attitude because it understood that such a conflictual attitude made it lose ‘a significant amount of credibility and influence’ in the negotiations. Moreover, the change to more cooperative relations was made possible by a change in negotiators and leadership of the FNV.

However, the changing attitude and personnel of the FNV were not the only reasons for the improvements in the quality of social dialogue. After all, during this period of conflictual relations, not only the FNV but also Zorgthuisnl withdrew from the negotiations on several occasions. The improvements also were aided by the collective decision of all parties to ‘improve the process of social dialogue’ – for which they hired an external agency. Together with this agency, they devised a ‘new way’ to organize social dialogue – emphasizing the shared interests of parties, rather than their conflicting interests.

The negotiations in this sector used to follow the ‘traditional’ format, in which unions on the one hand and employers on the other sent each other a ‘letter of demands’ before they started the negotiations. The innovation the social partners applied in this sector was to switch from this approach to creating a jointly determined ‘agenda’ for the negotiations. This makes the parties more ‘sharply focused on common interests’.

Still, some ‘subcutaneous tensions’ remain in this sector. In particular, professional organisations Nu’91 and FBZ prefer categorical over sectoral labour negotiations. Nu’91 feels that the sectoral organisation of collective bargaining hurts its ability to represent the interests of nurses and caretakers – independent of the organisations where they work. A ‘categorical’ collective labour agreement – which applies to a certain group of employees rather than a group of employers – would benefit their constituency. For example, the horizontal mobility of nurses between home care organisations and hospitals could be improved, as both groups of employees have different terms of employments despite doing ‘the same kind of work’.

Moreover, the national tripartite level of social dialogue is very important to the social partners in this sector. Key issues relevant to the parties concern national regulations or law and are not limited to the terms and conditions of employment. First, the financing of the Dutch LTC sector is considered needlessly complex by both employers’ organisations and unions. This because the Dutch LTC Sector is financed through three pieces of legislation: the Health Insurance Act [Zorgverzekeringswet], the Long-term care Act [Wet Landurige Zorg], and the Social Support Act [Wet Maatschappelijke Ondersteuning] (See above).

The financing system hinders both (most) employers and employees. Employers are dependent on a wide variety of actors to raise funds for their organisations. For example, Nu’91 notes the powerful position of insurance companies pursuant to the Health Insurance

Act. The employers need to account for their finances to these insurance companies to acquire funds for their business or organisation, but the insurance companies' only concern is costs, not the quality of care. Thus, for each budget the employer submits, the insurance company will attempt to pressure the employer into spending less than is absolutely necessary. Meanwhile, employees are hindered in carrying out their duties as the 'barriers' between these different sources of funds has the effect that the care services given to the client must be organized in such a way that they fit into one of these 'boxes', which is not realistic. In addition, both employer organisations and unions are critical of the system of public procurement by municipalities in financing home care. In fact, Zorgthuisnl and the FNV Zorg & Welzijn have jointly written a letter to the Ministry of Health, Welfare and Sports. They opine that – in order to cope with the pressures of decentralisation, austerity measures and public procurement – municipalities focus too much on cutting the costs in home care and pay insufficient attention to the quality of home care.

In contrast, ActiZ does not have a strong position on the issue of the undesirable consequences of public procurement in the sector. Because of the diversity of the organisations it represents, it lacks a clear 'common interest' and thus a mandate on this issue. For example, organisations financed through the Long-term care act are 'quite content' with public procurement, due to the clarity of tariffs.

In light of these financial issues, both unions and employers' organisations lobby the ministry to increase the budgets for the LTC sector. Both are faced with a relatively 'uncooperative government, which itself focuses on providing care at lowest possible cost'. To illustrate, Nu'91 participated in a 'scraping session' with the Ministry of Health, Welfare and Sport together with insurance companies and the labour inspection. According to the negotiator, this session was 'unsuccesful'. The goal was 'simply to scrape 400 rules' in order to ease the regulatory burden on staff. This focus on an 'arbitrary number of rules' points 'to the same kind of management thinking' without 'any concern for quality'. The negotiator felt that 'it was more cosmetic than anything else' and characterized this scraping session as a mere 'sop'. At the time that we finish this report (begin December 2022), all social partner organisations have just published a manifesto 'the employee on 1' ['De medewerker op 1'] towards the government in which they ask for extra funding from the government.24 ActiZ, Zorgthuisnl, FNV, CNV, FBZ and NU'91 point to the low wages in the sector, leading to low attractiveness for people to be employed in this sector and leading to financial problems among care workers. Again, they repeat the need of lower workloads for care workers.

Finally, the government is not equally accessible to all negotiating parties. In particular, employers' organisations have more and easier access to the Ministry of Health, Welfare and Sport than unions or professional organisations. This can be illustrated by the

[24] ActiZ ondertekent manifest: 1 miljard nodig voor de VVT | ActiZ

involvements of both ActiZ and Zorgthuisnl in the joint agreement with the Ministry about policies and measures in the care sectors (Integraal Zorg Akkoord, 2022).

5.3 Visual map op actors and relationships among them

This section displays the information above in short, graphical format. The stakeholders in social dialogue in the Dutch ECEC sector are presented in figure 5.1., while those in the Dutch LTC sector are presented in figure 5.2. Employers' organisations are colour-coded in orange, general unions are colour-coded in blue, and professional organisations acting as unions are colour-coded in green.

Figure 5.1.: Collective actors and their relations in social dialogue in the ECEC sector in the Netherlands

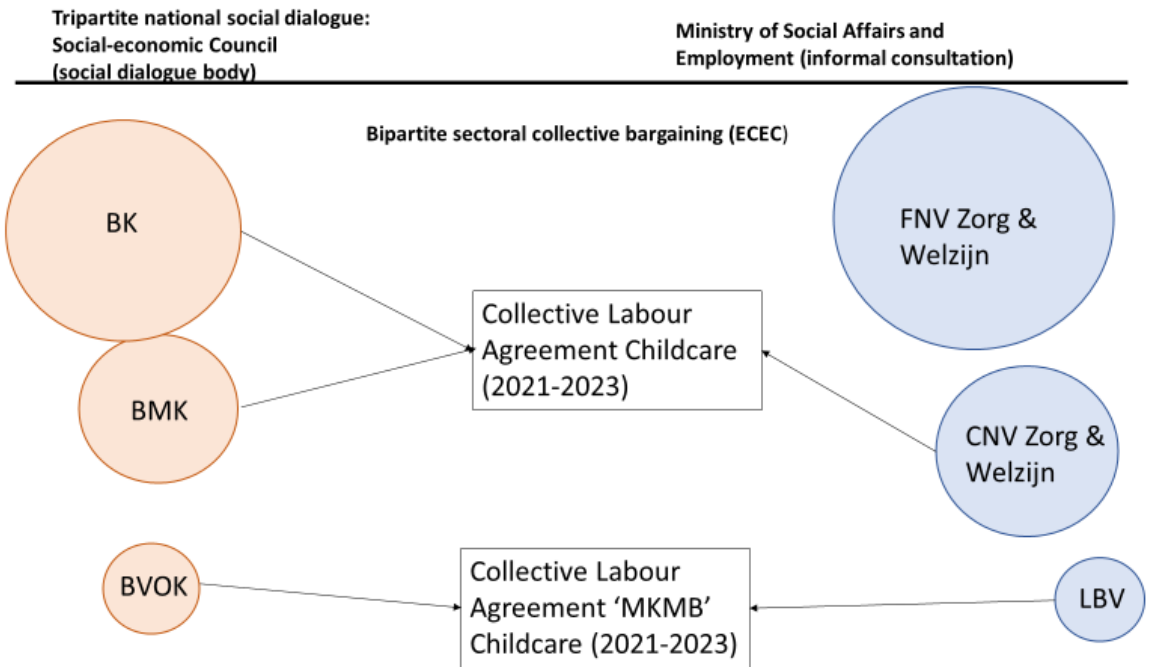
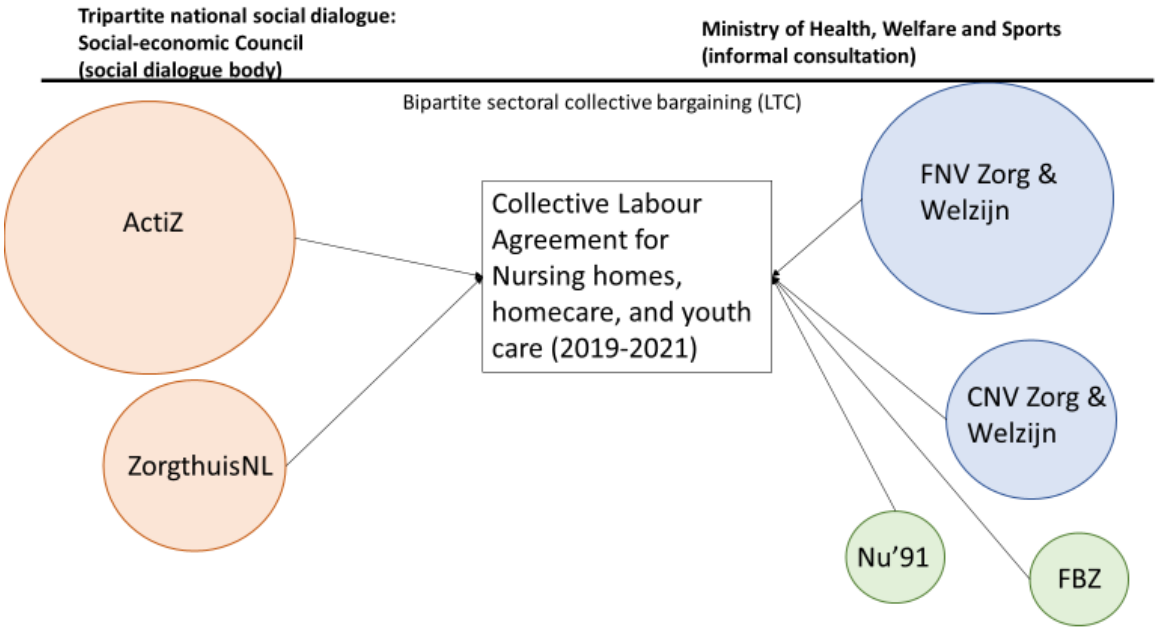


Figure 5.2.: Collective actors and their relations in social dialogue in the LTC Sector in the Netherlands



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Association	Type of association	Role	Sector
FNV/SER	Trade union/Tripartite social dialogue	Member commission 'care' in SER	LTC
Iederin	Clients'organisation in homecare		LTC
Ministry Public heath, welfare and sports	Government (state level)		LTC
VNG	Association of municipalities in the Netherlands	Senior legal adviser	LTC
Actiz	Employers' association	Legal policy adviser	LTC
Actiz	Employers' association	Policy adviser labour and social affairs	LTC
Zorgthuisnl	Employers' association	Governor and 1st negotiator collective bargaining LTC	LTC
FNV	Trade union	Governor and 1st negotiator collective bargaining LTC	LTC
NU'91	Trade union (for care-professionals	Public affairs and 1st negotiator collective bargaining LTC	LTC
Social Economic Council childcare	Social dialogue at national level	Employers representative	ECEC
BK	Employers' association	Governor and 1st negotiator collective bargaining ECEC	ECEC
BMK	Employers' association	Governor and 1st negotiator collective bargaining ECEC	ECEC
FNV	Trade union	Governor and 1st negotiator collective bargaining ECEC	ECEC
BvoK	Employers' association (SME)	Governor and 1st negotiator collective bargaining ECEC	ECEC