Social dialogue in welfare services in the Netherlands

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Part I: Labour market and employment relations in welfare services in the Netherlands

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) in the Netherlands is a not-for profit sector, but ion the same time 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.

Part II of this report is based on four case studies, two in the ECEC sector and two in the LTC sector. These innovative local practices are recommended or proposed by employment relations actors or dealing with the problems in the quality of labour or labour shortages in the wider care sectors that are addressed by these actors.

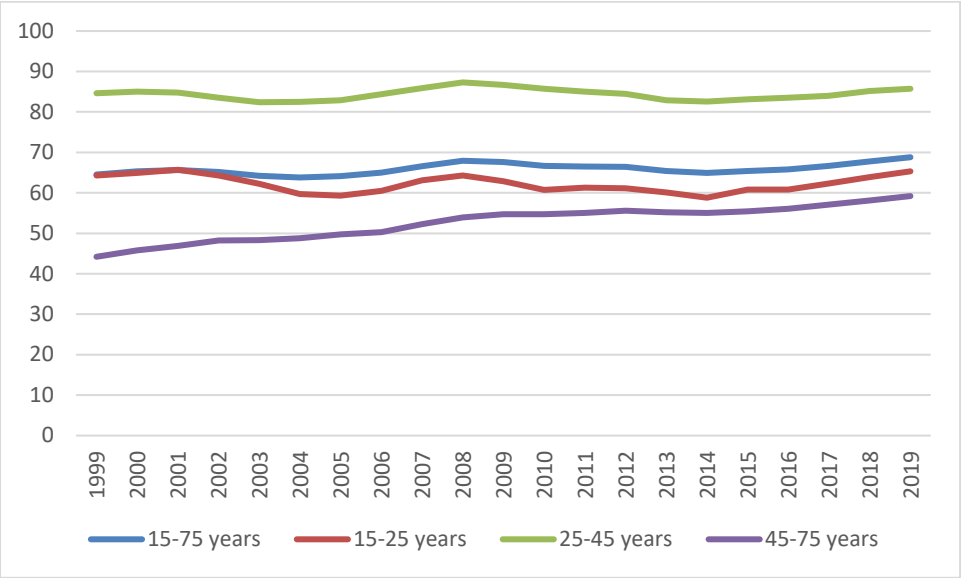
1. Labour market and employment in the Netherlands and its care sectors

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)

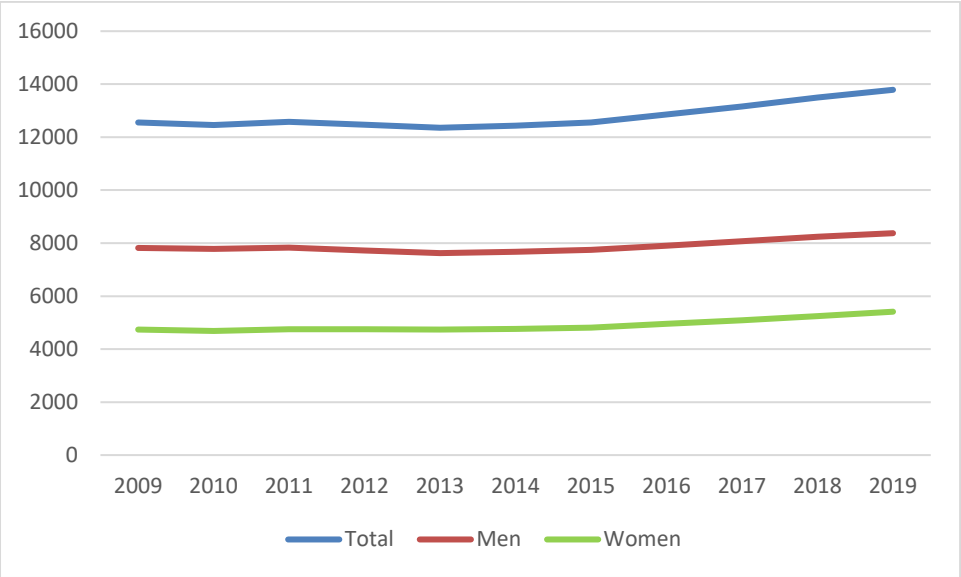


Source: CBS, Statline

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)

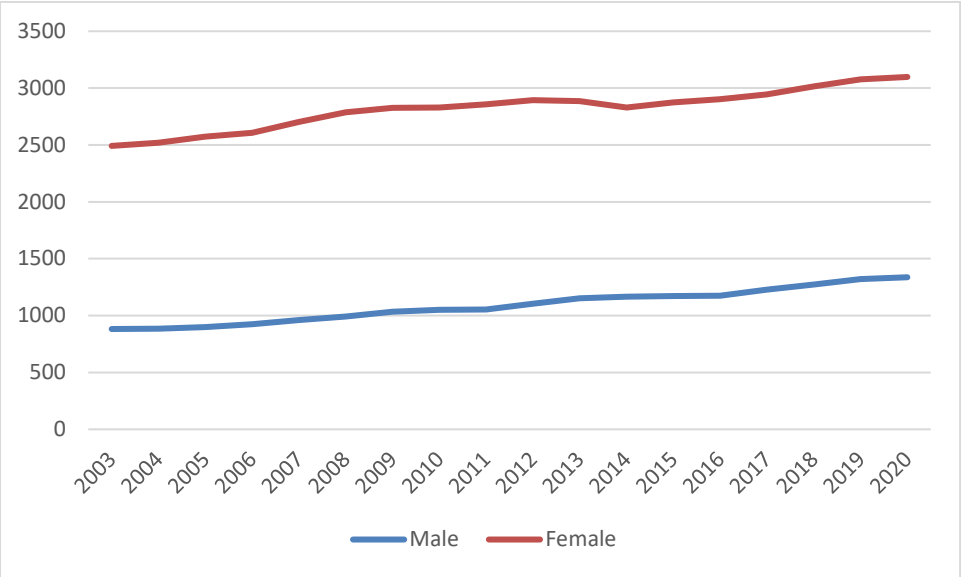


Source: CBS, Statline

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.

[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.

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

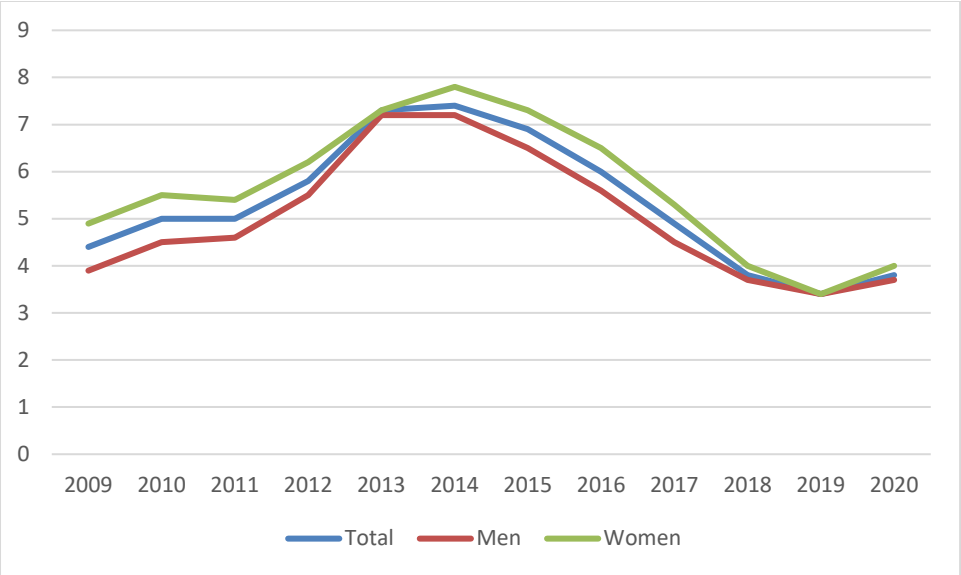


Source: CBS, Statline

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)

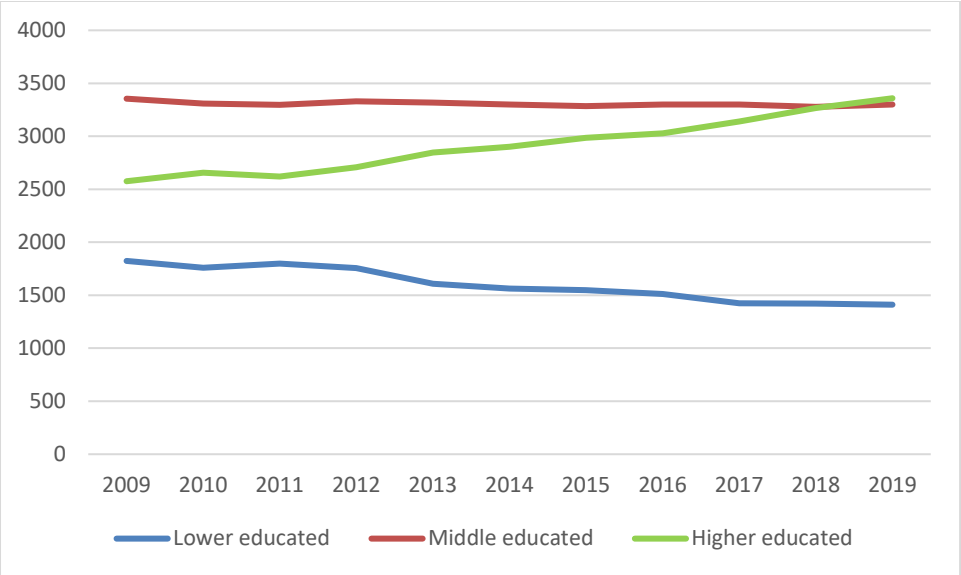


Source: CBS, Statline

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).

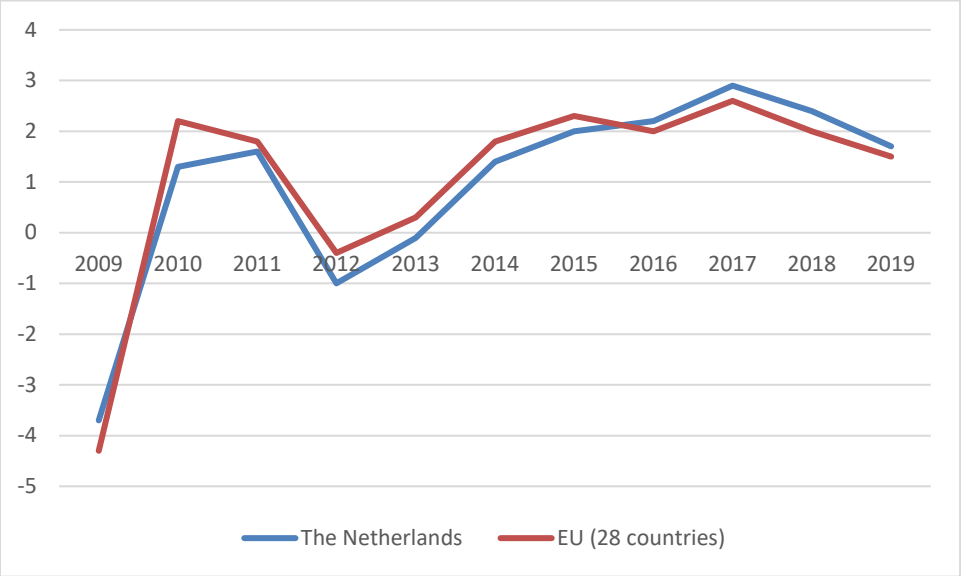
[3] Even higher growth within the female workforce in the Netherlands: 59%.

[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.

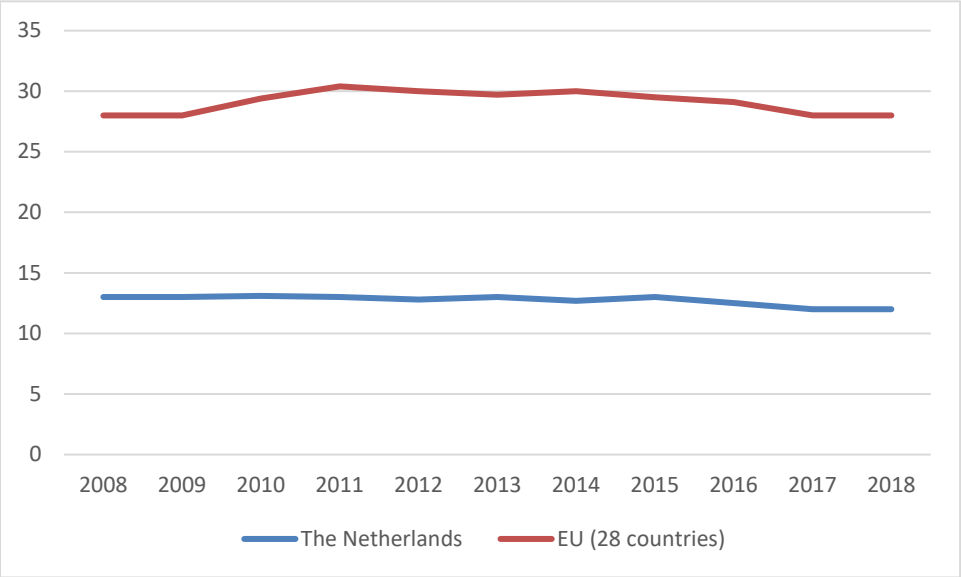
Figure 1.6. Yearly GDP growth rates 2009-2019, The Netherlands and EU



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

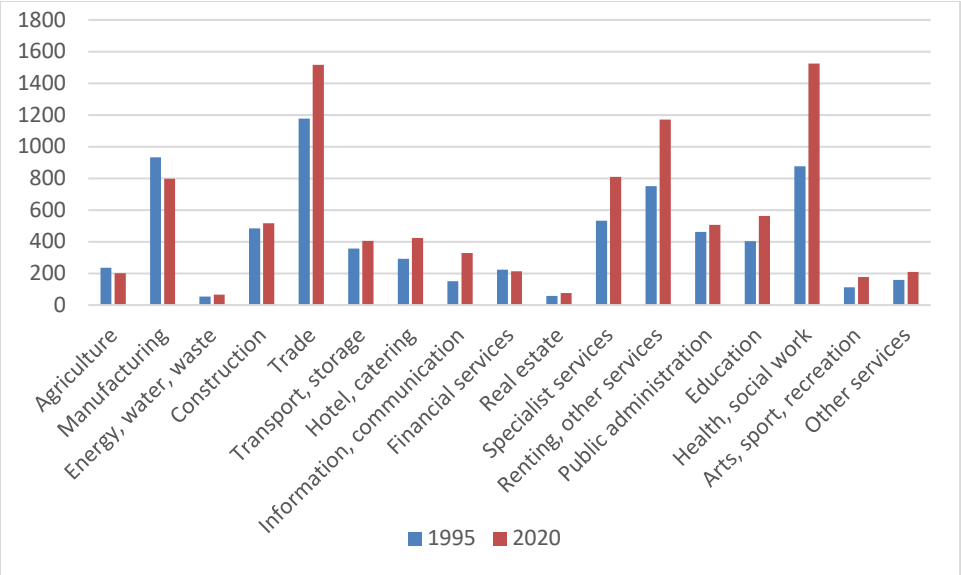
In sum, the Dutch labour market shows high employment rates, low unemployment, increased levels of education and increased numbers of older workers active in the labour market. But also very high numbers of women who work part-time and, as we will see later, a low performance with regard to the quality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

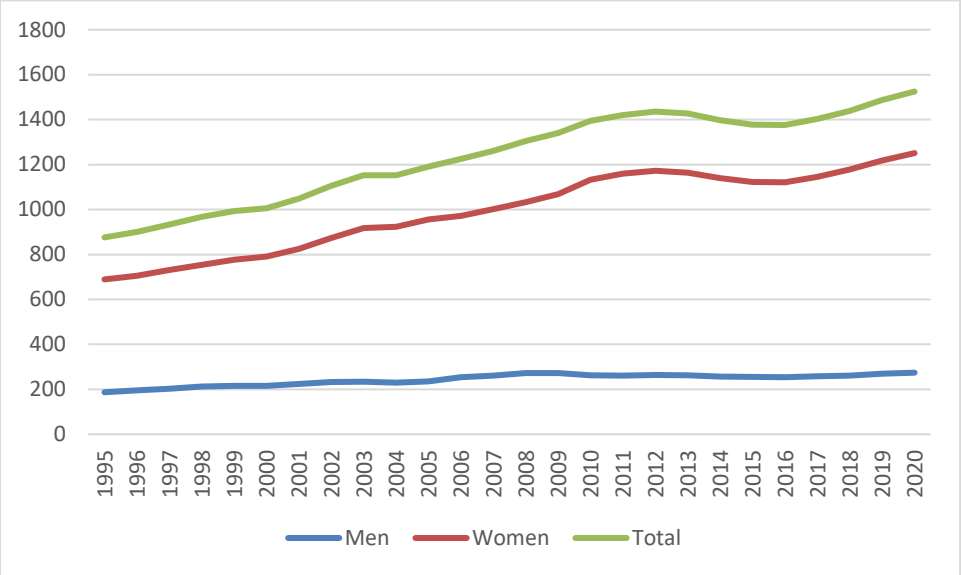


In 2020, 1,525,000 people worked in the sector of Health and social work. The vast majority of the workers in this sector are female: 1,251,000, 82 percent (compared to 78% in the EU). Figure 1.9 shows that the growth of employment in this sector mainly concerned women. In line with female workers in 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).

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

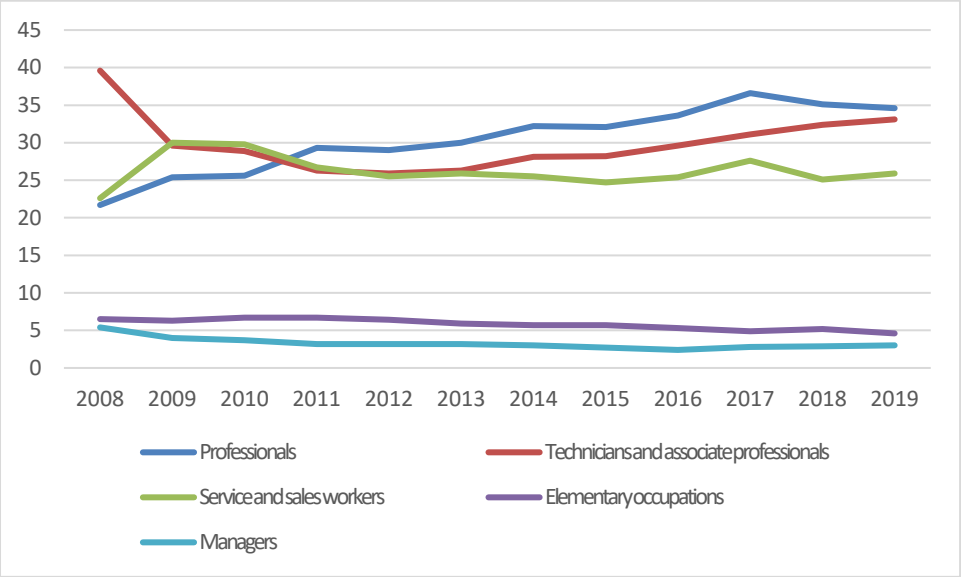
Figure 1.9. Number of workers in the Health and social works activities, 1995-2000, by gender (x1000)



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)

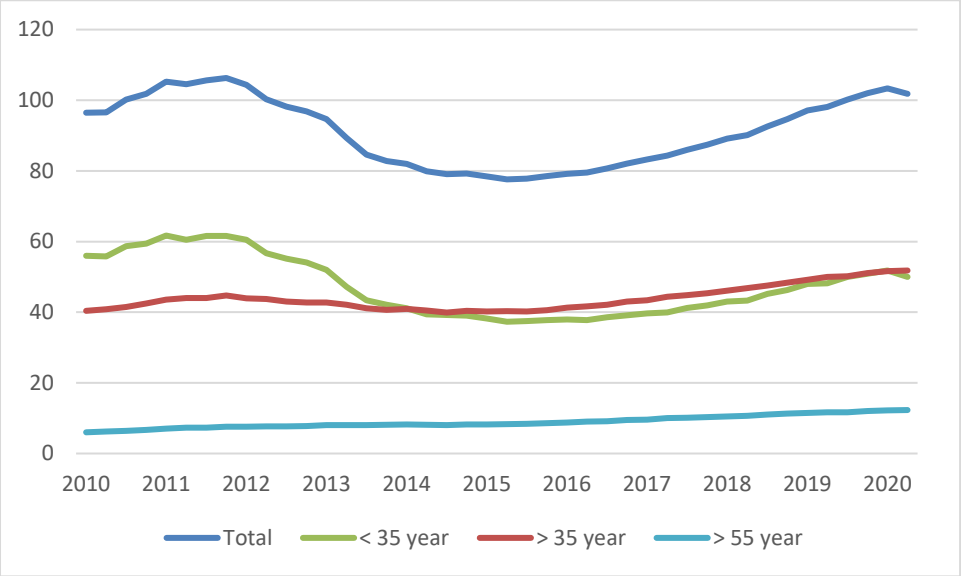
The share of older workers aged 50-64 years in the sector of Health and social work activities has increased substantially. From 27 percent in 2008, gradually to 35 percent in 2019. This development of ageing in the sector's workforce is similar to the situation in other European countries (SOWELL 2021: 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)



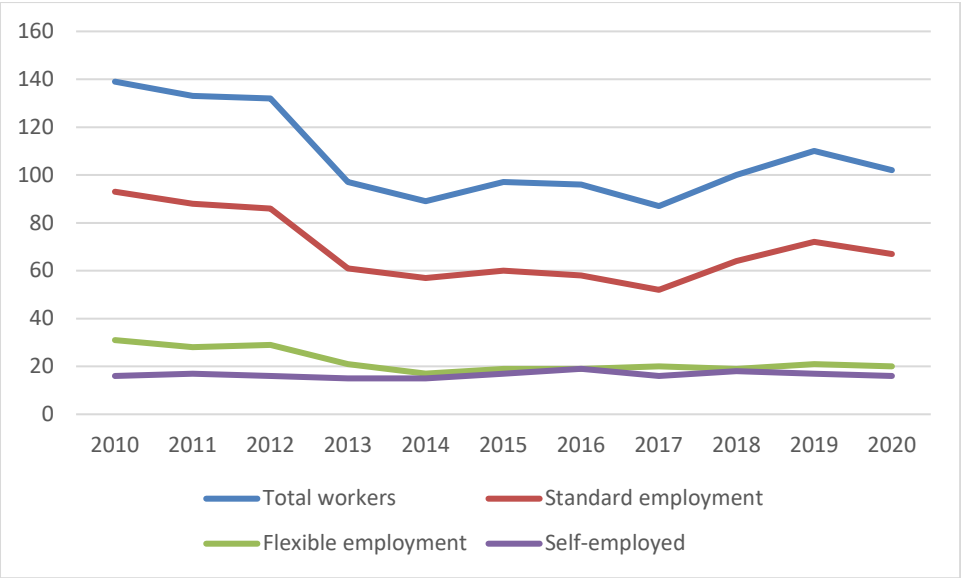
Source: CBS, Statline, AZW (note: category > 55 years is part of the category > 35 years)

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)

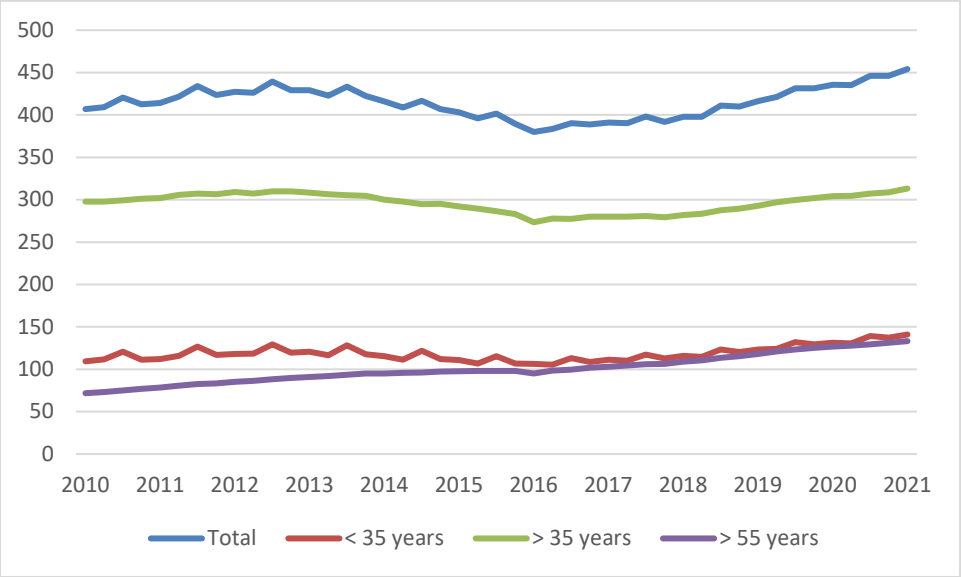
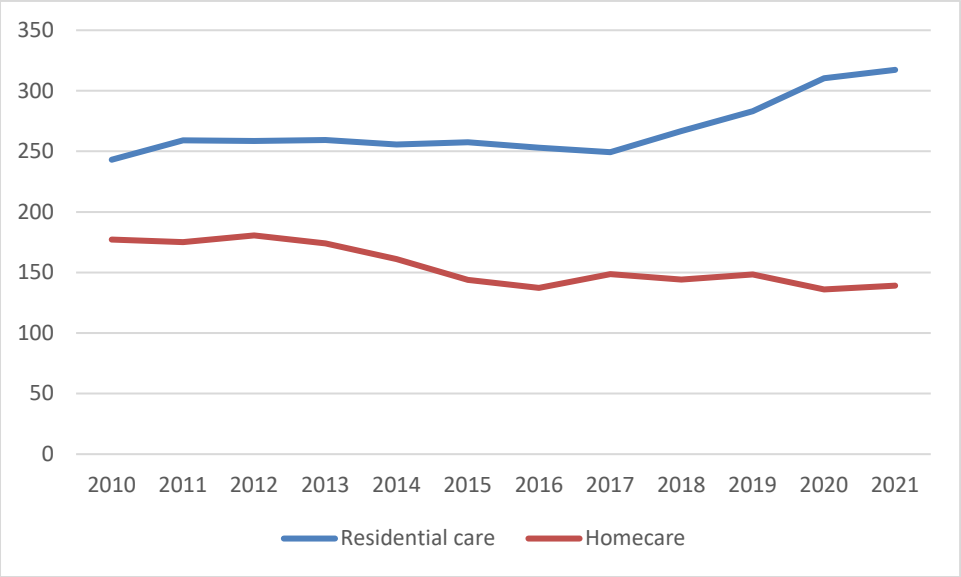


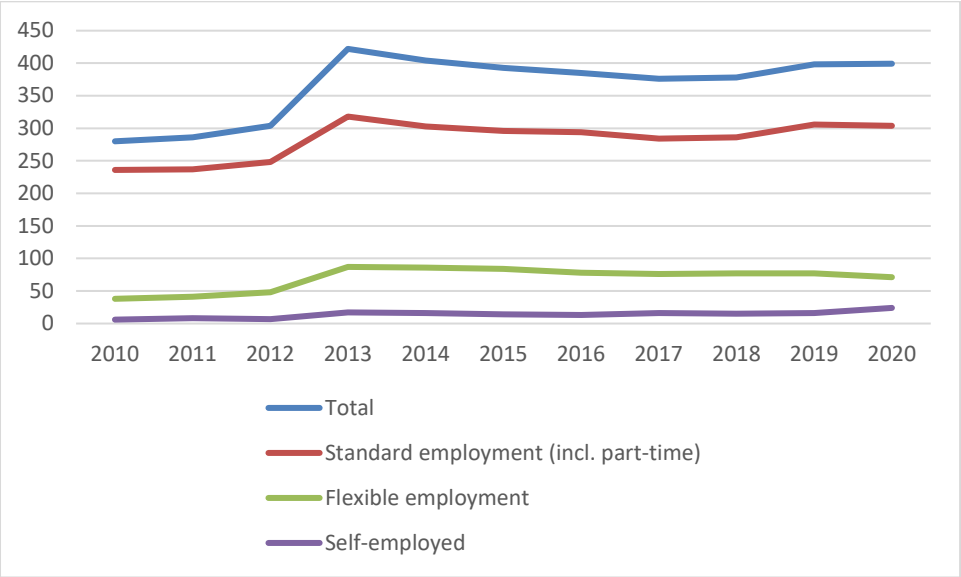
Figure 1.13a Number of workers in Residential long term care an Homecare, 2010-2021, all 3rd quartiles (x 1000)



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

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: 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

[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.

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 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

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

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

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

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). 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.

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

[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).

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 (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.

[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

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 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.

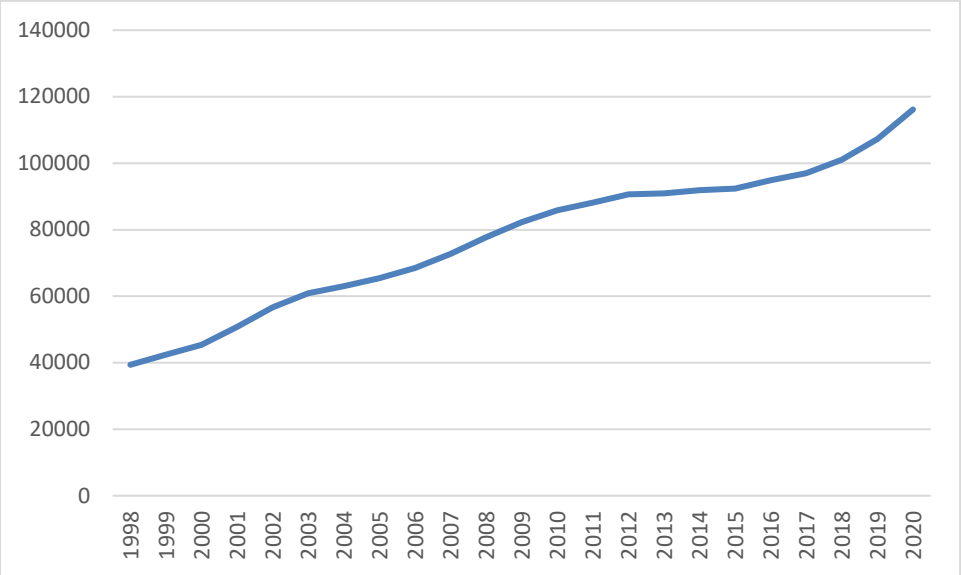
Figure 2.1 shows that expenditures in care have grown in the last 2 decades. In the 2000s, expenses grew faster because of investments to eliminate longer-standing waiting lists.

[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).

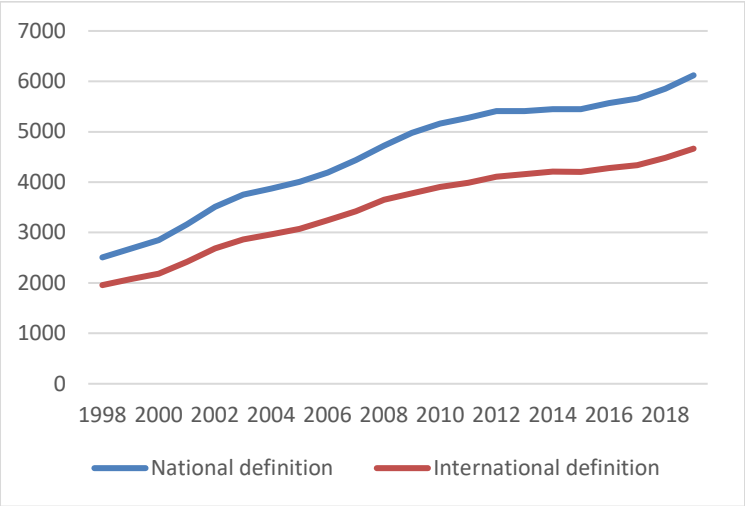
Nevertheless, in 2012-2015 expenditures grew more slowly as a result of public austerity measures, which can be seen as a delayed response to the financial crisis that started in 2008. Relative to the growth of GDP in the Netherlands, the expenditures even decreased after 2013. After 2019, care expenditures, 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).

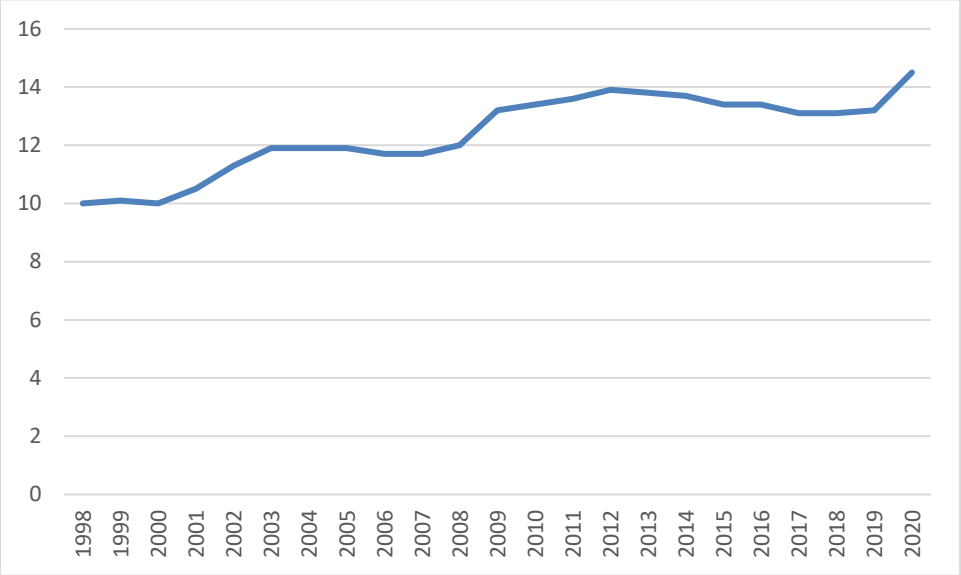
Figure 2.2 Care expenditure head of population, national and international definition, 1998-2019



Source: CBS Statline

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

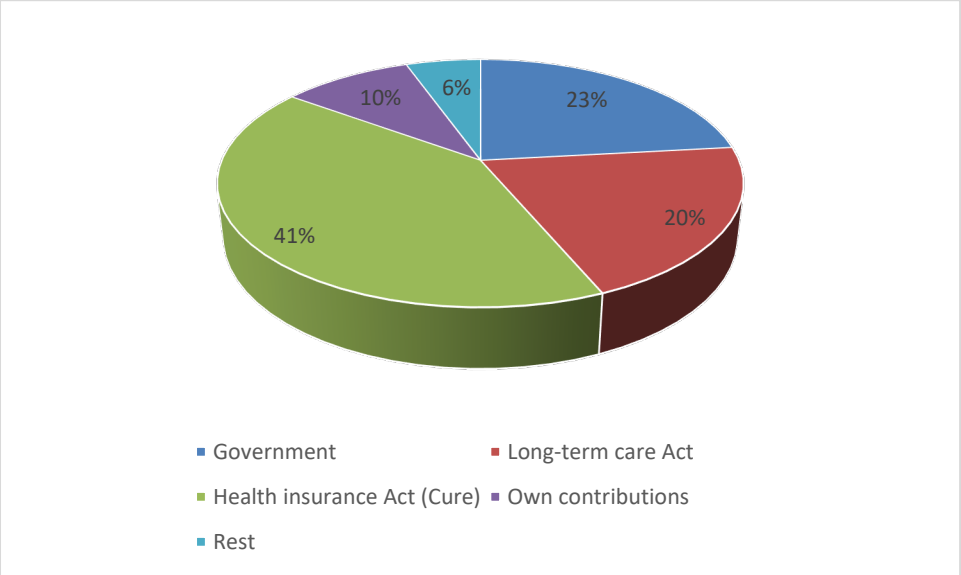
Figure 2.3 Care expenditures as percentage of gross domestic product, 1998-2020 (national definition)



Source: CBS Statline (september 2021)

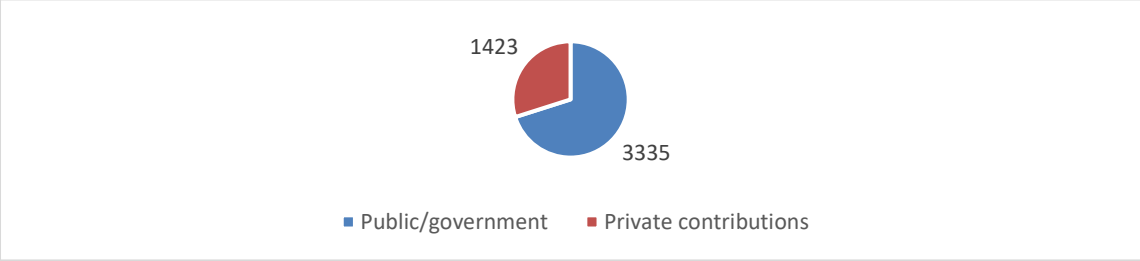
In 2020, the expenditures for health and care were € 6,600 per person (see fig. 2.4). These were financed for 41 percent by the Health Insurance Act (cure), 20 percent by the Long-term care Act, and 23 percent from contributions from the government. Private households paid 10 percent. The rest (6 percent) 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).

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

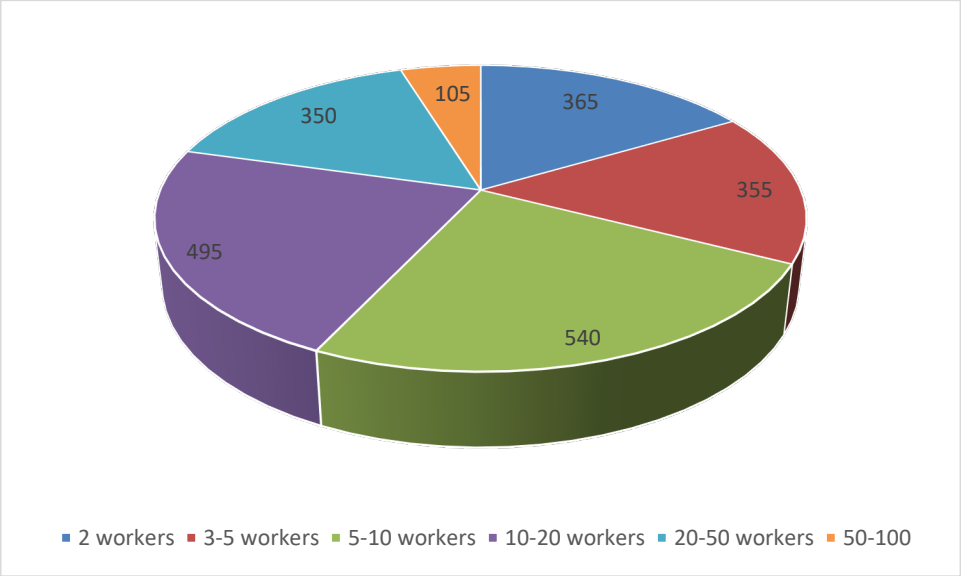
The Netherlands have a mixed system of providers, with a relatively large share of profit organisations (similar to the system in the UK). The demand-driven model of childcare in the Netherlands – introduced in 2005 - has indeed led to more 'for profit' organisations: from 40% in 2003 to 70% in 2010 (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

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

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

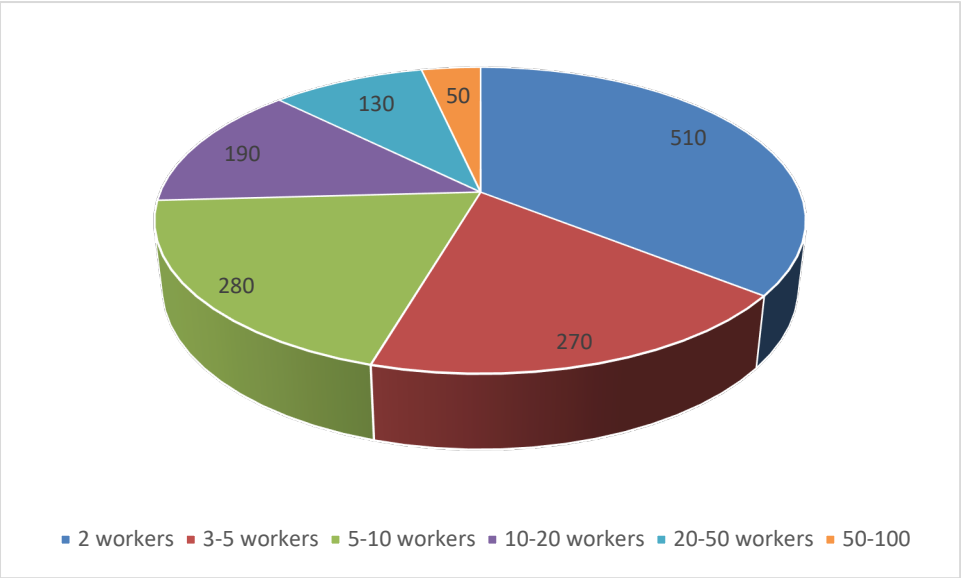


CBS, Statline

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.

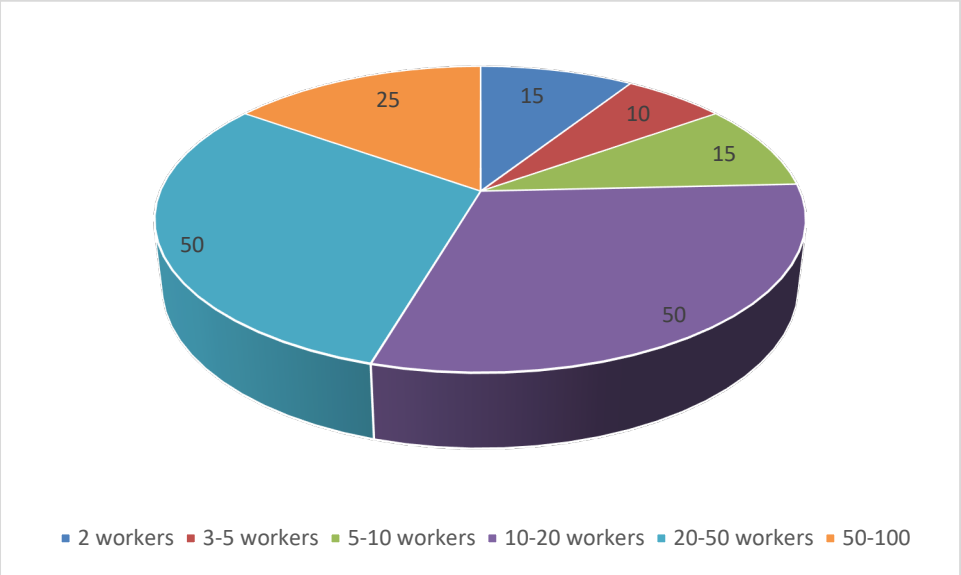
3.3 Number of homecare organisations by size (number of workers), mid 2021



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

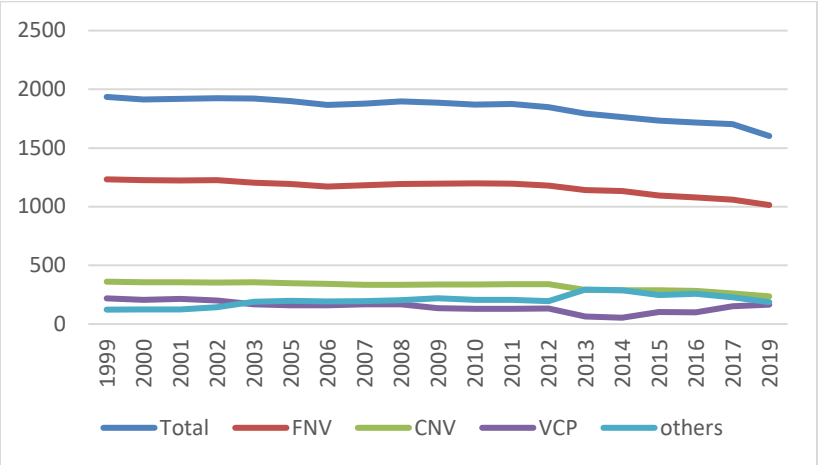
3. The employment relations system in The Netherlands

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.

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.

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 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.

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

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

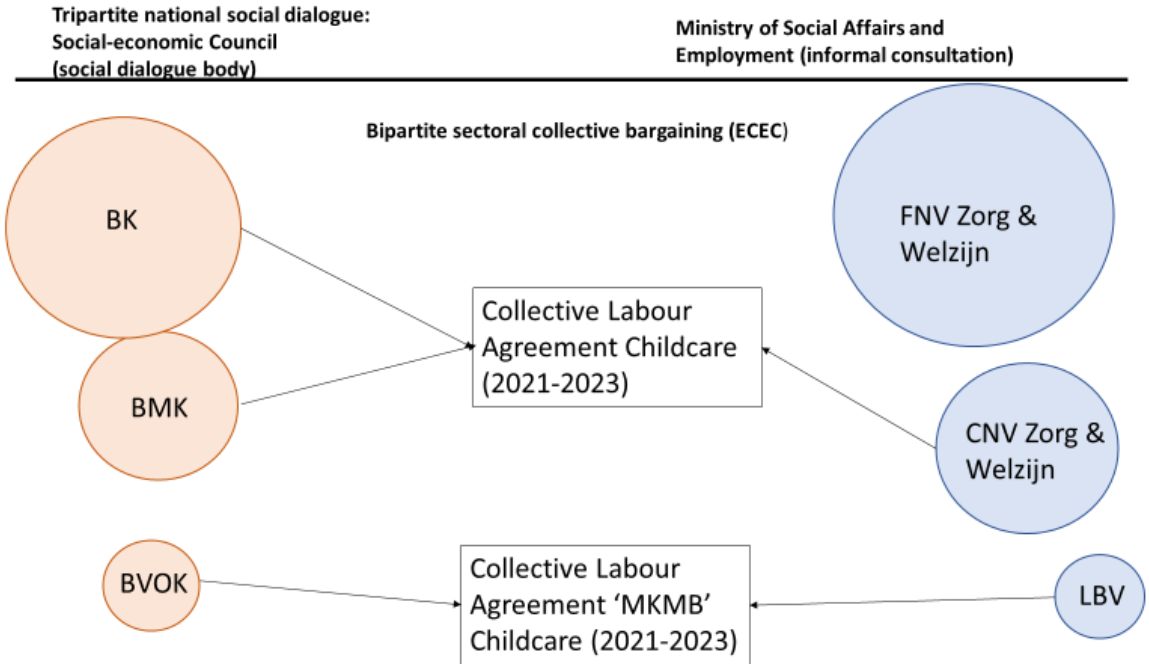
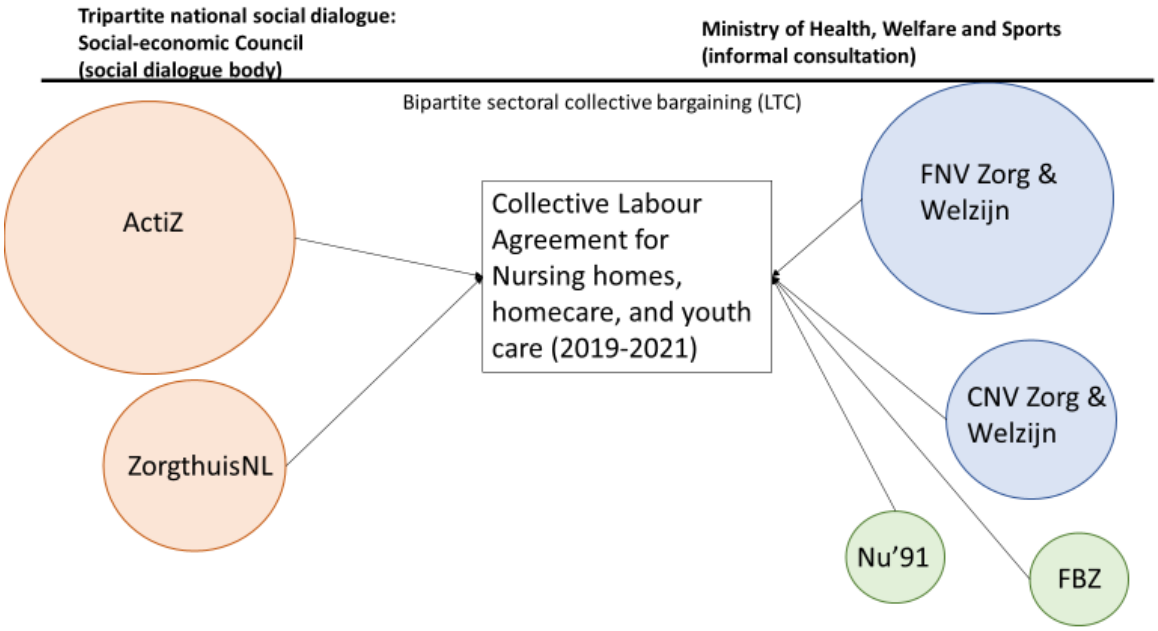


Figure 5.2.: Collective actors and their relations in social dialogue in the LTC Sector in the Netherlands



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List of interviews in Part I

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

Part II: Case studies on social innovation in welfare services in the Netherlands

Introduction

Part II of this report is based on four case studies, two in the ECEC sector and two in the LTC sector. As written in part I, trade unions and employers' associations in the Netherlands are active at the national and sectoral levels and have low institutional and hardly any organisation involvement at company and workplace levels. Therefore, case studies in the Netherlands focus on innovative local practices are recommended or proposed by employment relations actors or dealing with the problems in the quality of labour or labour shortages in the wider care sectors that are addressed by these actors.

The main problems relating to the quality of work in the Dutch ECEC sector revolve around unsustainable levels of working pressure, which are partly caused by, but at the same time contribute to the staff shortages in the sector (see part I). In addition, there are relatively limited opportunities for professional development for pedagogical staff within the sector itself (Interviews with BK, BMK, BvoK, and FNV). Finally, FNV stresses that too much flexibility is required of pedagogical staff – who often work part-time and in short shifts (Interview FNV).

Case 1: Child centre

In a report written in 2016 by the Dutch Social Economic Council, the integration of primary education and childcare services – traditionally quite separated domains and sectors in the Netherlands – is proposed as a fertile basis for improvements that benefit both children and workers. For children, such an integration would lead to better outcomes in terms of emotional and cognitive development and more equal opportunities with regard to educational attainment. For pedagogical staff, the interprofessional collaboration would improve their opportunities for professional development. In addition, by combining tasks in childcare and education, pedagogical workers would be able to acquire more (stable) hours of employment (SER, 2016).

The Social Economic Council recommends the further development of 'child centres', formal collaborations between schools and childcare organisations, which offer integrated childcare and primary education services (SER, 2016). A recent report on the current state of child centres in the Netherlands notes that the 'ideal' child centre is characterized by equal and intense collaboration between teachers and pedagogical staff, which offer fully integrated education and childcare services in a single building. This to offer the richest and most stable play and learning environment for children. However, in practice child centres vary greatly in degree of integration: the collaboration between teachers and pedagogical workers is organised differently, and in many locations it is simply not possible to integrate these services in a single building (Veen, Ledoux, Emmelot, & Gevers Deynoot-Schaud, 2019).

The organisation selected for the first case study in the Dutch ECEC sector is such a child centre. Not just any child centre of course, but a highly innovate one – featuring the most integrated locations known in the Netherlands (Kohnstamm instituut, 2019). In fact, one of its most integrated locations was the first in the Netherlands to receive the predicate 'Dalton child centre' (interview 8). This is a quality mark from the Dutch Dalton Association which denotes a high degree of integration between high quality Dalton childcare and Dalton educational services (Nederlandse Dalton Vereniging, 2020). In addition, this childcare organisation covers multiple locations. Some of these are highly integrated, but others are still working hard to achieve a higher degree of integration (Interview 1). Thus, this case is

also suitable to highlight the factors that support or hinder the integration of education and care, and the important consequences of integration for the quality of work and service. The case is in several ways related to wider employment relations in the ECEC sector in the Netherlands. First because of the above mentioned recommendation of the social partners in the Social Economic Council in 2016. Secondly, because of the question of whether such a child centre-organisation experiences less problems with the quality of work than the average in the sector. As written in part I of this report, trade unions (and employers' associations) in the Netherlands are not directly involved at the company level, but stimulate social innovation in the sector that could lead to better services and better quality of work. This case provides the social partners with (hopefully useful) information.
The first case in the Dutch ECEC sector is largely based on seven interviews with people from multiple locations falling under a single child centre organisation. Concretely, we spoke to the general manager and a HR manager from the central office (Interview 2, 8), one location manager and two pedagogical workers from different but highly integrated locations (Interview 5, 6, 7), and two pedagogical workers from one of the least integrated locations of this child centre (Interview 3, 4). In addition, we spoke to a program director of 'PACT for child centres' – a program designed to foster the development of child centres in the Netherlands (Interview 1).

Case 2: Recruitment and retainment of pedagogical staff

The employers' organisation BK stresses that child centres are not a solution that can be implemented throughout the sector. Such child centres typically employ 'alternative' pedagogical philosophies – for example inspired by Montessori or Dalton – which not all parents want for their children. In contrast, the members of BK, which are mostly commercial organisations or social enterprises, aim to use several innovative measures to recruit and retain sufficient pedagogical workers in times of staff shortages. These include offering more favourable working conditions (such as working hours), offering opportunities for professional development or novel ways of recruitment (Interview 9).
The second case in the Dutch ECEC sector deals with innovations undertaken by commercial childcare organisations. It is a commercial childcare organisation which uses several of the innovations that are typical of the commercial sector (more on which later) to recruit and retain sufficient pedagogical workers. This (combination) of good practices has the effect that, in the words of a representative of the BK, the organisation 'does not suffer' from the current staff shortages in the sector (Interview 9). Thus it may offer insights useful for more typical childcare organisations which hope to recruit and retain sufficient staff members, as compared to child centres specifically.
The second case in the Dutch ECEC sector is based on insights gained from four interviews: one with a policy officer of the employers' organisation BK, as well as the director, a human resources officer as well as a cluster manager of the childcare organisation. The cluster manager also used to be a pedagogical worker herself and has previous experience at other childcare organisations as well (Interviews 9, 10, 11, 12). The information from all these interviews is supplemented with insights gained from organisation websites and (policy) documents.

Case 3: regionalisation in home-based care

Part I of this report made clear that home-based care services in the Netherlands have suffered from problems relating to both the quality of services and quality of work following the joint introduction of public procurement, financial austerity measures and decentralization of services to the municipal level. The problems regarding the quality of services is captured

in the societal debates about the rise of 'care cowboys'. These are organisations that seek the grey areas of the law regarding their treatment of their clients or workers in order to maximize their profits. Meanwhile, the issues regarding the quality of work come down to four issues: a) relatively low wages, b) high working pressure, c) limited opportunities for professional development and d) much regulatory pressure and an associated lack of perceived autonomy (Interviews ActiZ, FNV, Nu'91, Zorgthuisnl).
The largest general labour union in the Netherlands, FNV, suggests that there is a clear link between the introduction of public procurement/decentralisation and these problems in the homecare sector: due to their modest resources and scale – both financially but also in terms of staffing and expertise – individual municipalities are not well equipped to procure these services as a rational consumer would: all kinds of unintended consequences may arise from the way services are financed or the suppliers of these services are managed. Therefore, FNV suggests that regional cooperation between municipalities in purchasing home-based care services might contribute to the solution of some of the problems. In this way, municipalities can pool their resources and set up a procurement process that has the effective ability to improve the quality of services and work in the region – given the constraints of municipal budgets (Interview FNV). This case aims to give more information on the set-up and effectiveness of a regional initiative, not only on the point of service provision but also on the point of quality of work for those working in homecare.
This case in the LTC sector centres around one such regional partnership (RP) in the Netherlands. The majority of municipalities are or have been part of such a partnership in the previous decades, making an RP not very innovative in and of itself (Uenk, 2020). However, the way in which the collaborating municipalities have professionalised their procurement process in this specific RP can be called innovative. First, they have introduced a novel method of public procurement called 'semi'-open house to reduce the number of care providers to a manageable level. Secondly, they have set up an integrated quality control and enforcement framework that is aimed at improving the quality of services and might also enhance better quality of work for homecare workers in the region.
This case study is based on nine interviews and selected policy documents and websites of the participating organisations. The large number of interviews makes it a relatively large case. This number of interviews was considered necessary because, as a regional collaboration, the case comprises several levels which must all be adequately covered. First, a procurement advisor, a relation manager and a quality controller from the RP itself. Second, representatives of both a larger and a smaller municipality involved in the collaboration: a senior policy advisor and a strategic policy advisor from the largest municipality, and a contract manager from the smaller municipality. Finally, representatives from the largest and a smaller, as well as profit and non-profit care providers in the region: a manager 'wmo' (social support act) from a larger non-profit organisation, a manager home-based care from a smaller non-profit organisation, as well as the director of a commercial care provider.

Case 4: self-organising teams in a nursing home

The other case mainly focuses on addressing the issue of regulatory pressures and the lack of autonomy perceived by workers in the Dutch LTC sector (Interview ActiZ, FNV, Nu'91, Zorgthuisnl). In the Netherlands, a model of self-governance by homecare nurses called the 'Buurtzorg model' (Neighbourhood care) has been highly successful in recent decades. It is reported to be very effective at improving the autonomy and decreasing the regulatory pressure on staff while at the same time improving the quality of service as experienced by clients (Monsen & Deblok, 2013). In fact, it is so successful that it has been adopted in other countries. Known as 'the Dutch model' it has been implemented in – for example – the United Kingdom (Lalani *et al.*, 2019; Leask, Bell & Murray, 2020), and the United States

(Gray, Sarnak, & Burgers, 2015). The main promise of the approach is that it improves both the quality of service as well as the quality of work: by allowing nurses to organise the care for patients themselves – such as managing budgets, organising staff planning and recruitment - they not only experience more autonomy but also provide better care corresponding to their own knowledge and experience (Monsen & Deblok, 2013).
The social partners in the LTC sector in the Netherlands have interests in having more knowledge and evaluation studies about experiences in the field and the further spread of best cases in self-organising teams and new leadership and management structures in the sector.[25] Problems of low professional autonomy in the sector are recognised (Tros & Kuijpers, draft).
Rather than adding to the plethora of research into the Dutch neighbourhood care model, the final case study comprises a local initiative to translate such a model to intramural, residential care. This offers an interesting case because the wholesale implementation of self-governing teams in residential care has been criticized in the Netherlands due to the managerial burden it places on care workers (Bouma, 2019; Zorgcentra De Betuwe, 2022). In fact, several large residential care organisations in the Netherlands have 'abandoned' this approach following disappointing results (ibid.). Organisations that continue on this path experiment with 'finding the right balance' between the level of autonomy and the support to be given to teams of workers. In this light, in Dutch residential care, there has been a trend away from 'self-managing teams' and to 'self-organising teams' (Nu'91, 2022). The selected organisation has never worked with 'self-managing' teams, and has since 2017 focused on developing 'self-organising' teams. Making self-organisation work has been described by its management as 'a dialectical process' which requires continuous attention and improvements (Interview 24). This case study thus sheds light not only on the implementation, but also on innovations with regard to self-organisation.
The final case study is based on three interviews with four people involved in a relatively small but growing residential care foundation. First, an interview with both the director and the business operations manager (Interview 23). Second, an interview with a care worker (Interview 22). Finally, an interview with a 'team coach' – role specifically designed in recent years to provide support to self-organising teams (Interview 24). In addition, insights have been gained from selected documents and the organisation website.

[25] Wie is de baas? Dubbelportret in de VVT (aovvt.nl)

Case 1: Integrated education and care in Dutch Child centres

The case study context

The history of child centres in the Netherlands is a combined story of top-down support through research and lobby activities, and bottom-up initiatives and pilots (Interview 1). The story starts in the years 2010-2013, when managers of educational institutions, youth care and municipalities formed several committees to discuss the in their eyes too sharply separated childcare and educational organisations in the Netherlands (VNG, 2014). In these committees, the practice and societal support for child centres were explored. These child centres should be one integral childcare and educational organisation, forming one legal entity which would offer a continuous trajectory of development for children aged 0 through 13 at a single location with a single pedagogical vision, based around equal interprofessional collaboration between teachers and pedagogical workers (Interview 1, VNG, 2013).
The idea for child centres was picked up by the The Childcare Fund [Het *Kinderopvangfonds*] in the program 'Pact for child centres' (Interview 1). This fund was set up in 2006, and has as its core aim to improve the quality of childcare services in the Netherlands. The fund was originally set up by the social partners, and historically focused on safeguarding the quality of work of pedagogical workers (Het Kinderopvangfonds, 2022). The program focuses heavily on organizing lobby activities and conducting research on the many bottom-up initiatives and pilots occurring in the Netherlands in creating childcare centres (Interview 1). Numbers are hard to come by, as there are no official statistics of child centres in the Netherlands. They are frequently counted amongst 'broad' primary schools, which have reportedly witnessed explosive growth since the turn of the century (Claasen, Knipping, Koopmans, & Vierke, 2008). In 2016 the tripartite Social-Economic Council recommended further development of child centres, as earlier written (SER, 2016).
The organisation in this case study houses some of the earliest and most integrated child centres in the Netherlands (Interview 8, Veen, Ledoux, Emmelot, & Gevers Deynoot-Schaud, 2019). It was set up 5 years ago after an administrative merger of several childcare organisations and primary schools. It serves roughly 10 thousand children with 1120 staff members, spread across 26 locations where education and childcare are integrated to a more or lesser extent, and also some completely separate childcare locations. The merger is only administrative, and formally the educational side and childcare side of the organisation remain separate legal entities. This is because there are different financial arrangements: education is the public sector, while childcare is privatized in the Netherlands. In addition, both sectors have their own collective labour agreements (Interview 2).
The organisation focuses on offering a continuous trajectory of development for children from 0 to 12 years of age. This in contrast to the 'hard cut' – which occurs when children are 'handed over' from childcare or pre-school organisations to primary education (Interview 2) This 'hard cut' occurs quite late in Netherlands compared to other European countries, namely at the age of 4 (Interview 1). Such a 'hard cut' implies many changes for the child – including going from a relatively small group of children to large classrooms, going to a different organisation and building, and being taken care of by different people. Adapting to this new context takes a lot of energy of the child, which could otherwise be spent on their own development (Interview 2).
The selected child centre employs a Dalton philosophy towards didactics and pedagogy (Interview 2). Dalton is an 'alternative' pedagogy compared to regular (either secular or Christian) primary education in the Netherlands. Although it is more 'a way of life' than a rigid, formal philosophy, its core tenets include, first, a focus on the broad development of

children including their creative and social development in addition to their cognitive development. Second, a focus on democratic values and developing citizenship. And finally, enabling children to function in complex societies by fostering entrepreneurship and individual responsibility (Dalton.nl, 2022).
The continuous trajectory offered by the organisation is designed to support the development of children in three main ways. First, acquiring useful skills and knowledge (qualification). Second, learning (humanistic) standards and values and developing socially-emotionally (socialization). And finally, developing individuality and intrinsic motivation (personification). The organisation sees a strong complementary potential between education and childcare in these domains. This in contrast to traditional education, which focuses more on qualification alone, and which leaves personification and socialization up to childcare organisations and the family (Interview 2).
As stated, the 26 locations falling under the organisation are integrated to a more or lesser extent – and therefore all have their own specific approach to childcare and (if applicable) education. While the organisation strives to promote the 'ideal' integration of education and childcare described above, it still recognizes that not all conditions allow for this ideal scenario. Crucially, it is not always possible to house childcare and primary education in the same building (Interview 2). In the Netherlands, primary schools are built with public funds, while childcare organisations hire or buy real estate privately (Interview 1). To capture this diversity, we spoke to staff members of two 'highly integrated' locations in which childcare and education are offered by a single interprofessional team in a single building (Interview 6, 7, 8), and one 'less integrated' location which offers childcare services in close collaboration with a nearby but separate primary school (Interview 4, 5).

The issue

First, one of the key issues in the quality of work where child centres could offer improvements is the lack of value and recognition given to the qualifications and skills of pedagogical workers. Pedagogical workers are given relatively little room to manoeuvre, even in 'quality-oriented' legislation such as the 'Innovation and Quality Childcare Act ((*Wet Innovatie en Kwaliteit Kinderopvang, IKK*). This makes them feel distrusted and belittled by, for example, the municipal health services, which control the enforcement of the Quality Childcare Act at the childcare, pre-school and after-school care organisations. To counter this, recognition of and trust in the professionalism of pedagogical workers is needed (Interview 2).
This lack of recognition of the professionalism of pedagogical workers has also been historically present in the education sector. Teachers are educated at higher vocational training institutes, while pedagogical workers are educated at lower or 'practical' vocational training schools. Their higher level of education may make teachers feel that pedagogical workers and their insights are 'beneath' them (Interview 3, 4). This sentiment is reflected in wider Dutch society, which harbours quite negative stereotypes attached to students or alumni in 'practical' vocational training schools. There is a strong ideal that everyone should be as highly educated as possible (BNNVARA, 2018; Lobosco, 2019). To illustrate this, national news has recently (29-10-2022) addressed the perception of lower vocational training schools as 'the trashcan of Dutch society' (van Prooijen, 2022). Contact and collaboration between teachers and pedagogical workers could be a way to reduce these negative stereotypes (Interview 1, 2).
Second, child centres are also a response to issues in the quality of Dutch ECEC services. As stated, early childhood development is impacted by the big changes children are introduced to when they transfer from childcare to education (Interview 2). In the Netherlands, this transfer

happens quite early in life as children are already taken under the wing of primary education at the age of four. This introduces two big changes. First, the professional to child ratio in childcare differs greatly from that in education. For toddlers aged two to four, regulations provide that there can be only six children for one pedagogical worker. Even in after-school care - for ages four to twelve, just like primary education – it is mandated that there should be one supervisor for ten children. However, in primary education there is only one teacher for class sizes up to 30 children. Second, primary education introduces the children to formal learning instead of the 'playful' learning that is central at childcare. Although the early years of primary education – for toddlers aged four to six – are still relatively informal, it is still a much more structured environment as compared to childcare (Interview 1). Child centres could offer a more 'continuous' line of development and offer a soft transition from childcare to education (Interview 1, 2).
Finally, child centres could address the inclusivity of childcare in the Netherlands. In the education sector, there are 'special' educational organisations focused on children with special needs or a development gap, known in the sector as 'children who have a little backpack'. In addition, there are special schools for highly gifted or uniquely talented children. Apart from specific pre-school arrangements for children with a development gap, there is no such diversity in childcare. Due to its 'alternative' pedagogical philosophy, child centres generally focus on the specific talents of specific children in an holistic manner. This could also lead to a more inclusive organisation of childcare services (Interview 2). In fact, one of the locations participating in this research cares for an 'unusually high number' of highly intelligent children and employs a 'coach' specifically to support the pedagogical workers in tending to these children (Interview 8).

The process

Child centres have proliferated and developed in the Netherlands largely bottom-up, on the initiative of primary education organisations which were of an 'alternative' persuasion such as Dalton or Montessori elementary schools (Interview 1, 2). In the first years of the 21st century, these schools started to incorporate childcare into their organisations and these have in some cases developed into child centres (Interview 1). For example, the child centre organisation central in this case study developed largely out of a partnership of existing childcare organisations and primary schools (Interview 2). In addition, there are child centres which are fortunate enough to be founded and built as a child centre from the start – typically as part of a newly constructed neighbourhood (Veen, Ledoux, Emmelot, & Gevers Deynoot-Schaud, 2019). This also applies to one of the locations that belongs to the childcare organisation in this case study (Interview 6, 7). This bottom-up development causes that childcare organisations and locations vary greatly from one another, and differ in their degree of and approach to integration of education and childcare (Interview 1, 2).
The child centre organisation in question was not set up overnight. 'There were incredibly many bears on the road', the director explains (Interview 2). It started as a quite complex collaboration between two childcare organisations and neighbouring school boards. The two childcare organisations had acquired different locations in their time, and these needed to be 'traded' in such a way that childcare and educational services would be as close to one another as possible. This process was arduous and difficult, and in the end cost the organisation around three years (2016 – 2018) and one-third of their locations and staff (Interview 2).
In 2018 the childcare organisation got a single name, and from then on it started to see itself as a single organisation. Technically it is not a single legal entity, since education and childcare are funded differently (more on this later). 'That is when the real work started'

explains the director, ‘now we had one organisation but the people still had to find each other’ (Interview 2). The experience of one of the managers illustrates how people from different organisations were integrated. The manager worked at a small organisation of 60 staff members, which was acquired by the childcare organisation in 2018. In the beginning, collaborating with each other was difficult. The manager and their colleagues were not used to working in a large organisational environment, as previously they worked quite informally and on a personal basis. In addition, the first years there were feelings of rivalry and ‘us versus them’ when it came to the various childcare locations. This was different in education, which is historically much more cohesive, partly due to its almost completely public character (Interview 3).

The approach taken to organisational integration by the childcare organisation was to start at the level of interpersonal connections, then develop the desired principles, values and standards (organisational culture) and finally structure the processes and rules around these connections and this culture. First, they organised meetings amongst the 60 managers in the organisation. Thereafter, management formulated the organisation values and principles. Importantly, the key aim of the organisation is to create a ‘continuous trajectory of child development’ rather than focusing on the label of a ‘child centre’ as such. A ‘true’ child centre is not a feasible or desirable solution at all locations (Interview 2).

Central management has formulated two key principles for the organisation: trust and growth. These principles apply both to the children and to the workers in the organisation. The organisation recognizes the pedagogical workers as their most important asset, as they are the ones who make a difference for the children. On the one hand, pedagogical workers are encouraged to trust their own judgment and professionalism. They often feel inadequate due to the many specific rules they need to comply with, the strict control from the municipal health services and their status difference with teaching staff. On the other hand, these principles also mean that workers are people first and employees second. In line with the ‘holistic’ image of humans from the Dalton philosophy, employees are both people and professionals. It is acceptable to be vulnerable, to feel bad and not always perform at your best. This creates a more relaxed atmosphere (Interview 2).

As stated, there are salient status differences between teachers and pedagogical workers in the Netherlands. Child centres often have to work hard to integrate teachers and pedagogical workers on an equal footing in interprofessional teams. Teachers tend to treat pedagogical workers as assistants or lackeys, rather than equal colleagues (Interview 1). The childcare organisation in this case is no exception, and creating and maintaining an equal collaboration between teachers and pedagogical workers is a continuous process. One important development was made when the organisation changed from having one management for education and another one for childcare to a single central management and a single ‘service desk’ for the support of both teaching and childcare staff (Interview 2, 3). The location management still varies for each childcare location, as they are in different ways integrated with primary schools. Typically, however, location managers are employed based on a general profile falling under the general labour agreement of primary education. This because such positions are more easily organised and financed based on this agreement as compared to the general labour agreement of childcare (Interview 2).

Contrasting the development of interprofessional collaboration between teachers and pedagogical workers between various locations illustrates the diversity and challenges therein. To start with, one of the most integrated locations was founded in 2020 and is housed in a single, newly-constructed building as part of a new neighbourhood. Since its inception, it consist of a small team of teachers and pedagogical workers, all of whom have worked here since the start of the organisation. The organisation is composed of several units organised around a central ‘restaurant’ where the children and staff members eat together. Pedagogical

workers and teachers are all referred to as 'team members' and they work together on an equal basis. They tend to the children in 'vertical groups' which cover various ages: there are units from zero to three, three to six, six to nine and nine to twelve years old. Often, the parents of the children do not even know who is (technically) a pedagogical worker or teacher. According to the employees themselves, having all started together and working in the same building has boosted their equal collaboration enormously (Interview 6, 7).
More typically, locations start out as relatively split managerial 'units'. With one manager for education and one (assistant) manager for childcare. Equal collaboration between teachers and pedagogical staff is then aided when the location is eventually brought under a single manager, together with increasing contact and collaboration between teachers and pedagogical workers (Interview 2). One of the more integrated locations participating in this study developed according to this more typical route (Interview 8).
In contrast, the collaboration between education and childcare at a less integrated location is much less robust. This location offers pre-school and childcare services, and has a close partnership with a nearby school. This partnership started in 2015, and in these early years pedagogical workers often visited the schools and the older children of the school and regularly read stories aloud to the toddlers in childcare. However, with the arrival of new director this partnership waned. Since then, there has been a new school director every one or two years and the degree of collaboration varies greatly depending on the time and interests of the directors (Interview 5).
Since 2020, this location can work with a school director which is very keen on promoting the collaboration between pre-school and childcare on the one hand, and primary education on the other. The older children at the primary school once again read aloud to the toddlers in childcare once a month, and the toddlers can play on the school grounds twice or thrice per week. In short, the degree of collaboration varies strongly based on the interests and possibilities of school management and staff. That this location does not share a building with the primary school makes a big difference in this regard. This does not only create logistical issues, but also has the effect that the teachers and pedagogical workers meet quite infrequently – mostly when transferring children from pre-school or childcare to school (Interview 5).
Apart from the continuous development towards integration of education and care, the childcare organisation has also made steps to foster the professional development of its pedagogical workers (Interview 2). The organisation offers several free workshops, lectures and three yearly field trips on pedagogical topics, and there is a budget to attend self-selected courses (Interview 2, 4, 6, 7). To follow these courses, each pedagogical worker has a professional development budget of 500 euro's based on 1 fte. The height of this budget is based on the collective labour agreement of primary education, but for the sake of fairness it also applies to the pedagogical workers (Interview 2).
More recently, in early 2022, the organisation has also developed an internal educational track for 'childcare worker'. Here, people are educated specifically to work in an interprofessional setting where education and childcare are combined in a continuous trajectory of child development – and they are trained in practice in one of the 29 locations. In addition, alumni of this internal educational track are guaranteed a position as a 'child centre worker' – in which they can function both as a pedagogical worker or a teaching assistant (Interview 2). The alumni are also employed to work in both pre-school, childcare or after-school care combined with assisting in teaching (Interview 3).
Students who have enrolled mainly come from outside the organisation itself. This is unfortunate, as most pedagogical workers are trained at upper-secondary vocational education level 3 (MBO-3), while completing the track would raise their educational attainment to the next level (MBO-4). The organisation has found that the main obstacle to

participation of many of its pedagogical workers was that they would have to follow the entire track. Many things would already be known to them and have no additional value for them, but nevertheless cost them their free time. Therefore, an innovation the organisation may implement next year is to divide this track into modules. For example, a part on after-school care and a part on teaching assistant. This would decrease the overlap with the current qualifications of staff and decrease the workload (Interview 3). As this innovation still has to take place, it falls outside the scope of this research.

The solution

The integration of education and childcare offers opportunities to improve the quality of work for pedagogical workers in several ways. One of the more straightforward benefits is that it allows pedagogical workers to work more hours. For example, they can expand their work in pre-school, childcare and/or after-school care – which often leads to short shifts – with work as an assistant in primary education (Interview 3). Moreover, in the fully integrated locations both teachers and pedagogical staff make 'long working days' from nine to five (Interview 2) – which is a lot more than regular Dutch childcare, where workdays often end at noon (pre-school) or two o'clock (childcare) (Interview 4).
Second, integration with education improves the opportunities for professional development amongst pedagogical workers. For example, by taking on tasks as a teaching assistant they can learn about didactics and group dynamics of older children (Interview 3). More generally, an integrated child centre allows workers to 'expand their horizons' (Interview 3). Often, pedagogical workers are interested in quite a specific age group when they enter the labour market. For example, babies aged zero to one, whose development and care is a whole different ball game compared to toddlers aged two to four. By working in an integrated setting, pedagogical workers come into contact with children of all these age groups and the colleagues caring for them (Interview 4, 5). Typically, working somewhere else – for example when filling in for a sick colleague – sparks the interest of the pedagogical workers. Especially when they meet children they have cared for at a younger age. This makes people think more about their career and expanding their pedagogical skillset (Interview 3). Dissatisfaction at professional career opportunities is one of the main problems among pedagogical workers in the childcare sector (see National Report SOWELL-NL).
Third, integration between childcare and education improves the job satisfaction of pedagogical workers because they are able to see how children they have cared for fare later in life (Interview 3, 6, 7). Even in the least integrated location, pedagogical workers have indicated that one of the main factors motivating them to organize collaboration with the nearby primary school is that they can see the children develop. It feels good to form an interprofessional team of pedagogical workers, teachers and social workers 'around the children' and make sure these children are offered optimal opportunities (Interview 4, 5). For example, one pedagogical worker cared for a girl in pre-school who was a refugee from Syria. The girl did not speak, but the worker saw a lot of potential in the child. She organized a 'warm takeover' with the primary school – which is an intense transfer trajectory with many talks and meetings. The point of these meetings was to allow her to attend a regular primary school, rather than send her to a 'special' school for children 'with a little backpack'. A social worker from the municipality also guided this process, and in the end the girl was able to go to the regular primary school. The pedagogical worker explained with a sense of satisfaction: "It is beautiful to all stand around the child and ask yourself: "What is the best we can offer them?" (Interview 4).
Fourth, integration may also improve the job satisfaction of pedagogical workers because they feel more valued for their professionalism and skills (Interview 2). This is especially true

for more integrated locations, where an equal collaboration between teachers and pedagogical workers has been achieved (Interview 3). As stated, in the newly built, highly integrated location there are no informal differences in nomenclature for teachers or pedagogical staff – all are referred to as 'team members' to promote equal collaboration. Moreover, there are many meetings and moments of informal contact between teachers and pedagogical workers: There are daily meetings, which are more directly work-related (although in line with the 'Dalton' philosophy there is space for personal issues). There is also a monthly 'building conversation' where all workers discuss the development and future of the child centre. Around eight times per year there are joint dinners, where teachers and pedagogical workers cook for each other and eat together. Four times per year there are 'domain meetings', where colleagues tending to the various domains (i.e. zero to three year olds, three to six year olds etc.) meet and discuss the progress of children and the organisation of the work. Finally, there are two yearly meetings. One 'building day' where management, teachers and pedagogical workers discuss the building itself and the physical organisation of space, and one two-day teambuilding event. All this contact makes your colleagues feel like family and makes both teachers and pedagogical workers feel at home with one another (Interview 6, 7).
That pedagogical workers need to collaborate and have contact with teachers on an equal footing to feel professionally valued is also evidenced by the experiences of workers in the least integrated location. Here, there have been many changes in the management of the primary school they collaborate with. The pedagogical worker notices that with each new school director, she needed to 'start from scratch' in building understanding of what the pre-school organisation actually does and what the work of pedagogical workers entails. As she explains: "This lack of respect is persistent. Sometimes there are teachers who do not even know what pre-school is. That indicates that there is something wrong with the education of the teachers as well." This pedagogical worker did notice improvements in the last years, now that there has been a director for two years who is also interested in increasing collaboration between the primary school and pre-school and childcare (Interview 4).
In the interest of equality it is good to note that the integration of education and childcare is not only beneficial for pedagogical workers, but also for teachers (Interview 1, 2, 8). In traditional Dutch primary education, there is one teacher who teaches an entire class the whole curriculum for an entire year. But in a child centre, the teachers are supported by pedagogical workers and can specialise in certain subjects. For example, a teacher in math and another in history (Interview 1). Moreover, through interprofessional collaboration teachers can learn and professionalise as well. Pedagogical workers are traditionally more accustomed to dealing with parents of children, who they see much more frequently than teachers normally do. In addition, pedagogical staff focuses much more on the socio-emotional development and personhood of the child and not only on qualifications or bureaucratic skills (Interview 2). For example, in one of the more integrated locations teachers also operate as 'coaches' who support the pedagogical staff on specific issues, such as dealing with highly intelligent children or implementing the 'Dalton' pedagogical vision in childcare. This also enables them to develop more pedagogical skills in addition to their didactical skills (Interview 8).
The integration of education and care is not only beneficial for the quality of work, but also for the quality of service for the children (Interview 1, 2). For example, in the newly built location, children can make a soft transition from childcare to education. The units are organized in 'vertical groups' in which the unit for children of three to six covers in several years a transition that traditionally takes place overnight. Children from the unit of one to three year olds can also have a few 'try out days', where pedagogical staff and teachers can observe and evaluate how the children handle themselves in the new unit (Interview 6, 7).
Also in the least integrated location, having interprofessional collaboration with the

pedagogical workers and teachers at the primary school benefits the transition of children, as the earlier example of the Syrian girl illustrates (Interview 4).
Moving on, there are mixed feelings about the internal courses and educational opportunities offered at the child centre in question. On the one hand, several pedagogical workers appreciate the free workshops, lectures and courses a great deal. In line with the 'Dalton' philosophy, they are able to freely choose their own workshops which may be work-related (i.e. how to work in 'vertical' groups) or personal in nature (i.e. exploring your hobbies). These staff members appreciate the level of autonomy they are given in their own development (Interview 5, 6, 7). On the other, one pedagogical worker indicated that the workshops and lectures may be a bit too unfocused. This employee used to work only in a pre-school setting, but now her organisation also offers childcare and after-school care. The workshops available at the location have diversified as a result. However, she herself has a quite specific interest in caring for and stimulating one to three year olds in a pre-school setting. She complains that previously all the workshops used to be interesting, but since these child services have merged in one organisation, there are quite a few workshops and courses she finds boring – such as those on caring for babies, or on telling 'cute' stories to parents (Interview 4).

The implementation

During their development and spread, child centres had to overcome many obstacles, some of which persist to this day. To start with, many earlier lobby activities at the turn of the century had failed. These were the high days of neoliberalism, and the integration of childcare and education was seen as a risk, since it might imply that childcare would also become a public good (Interview 1). Even today, the employers'organisation representing the commercial childcare organisation stresses that child centres are not a desirable solution in every situation (Interview 9). Organisations such as 'Pact for child centres' still encounter opposition from the more commercially oriented childcare organisations and their representatives, which still fear that integrating childcare with education would mean that childcare becomes a public service and a basic right for children or their parents (Interview 1). The childcare organisation central in this case would indeed prefer that childcare becomes a public service. Since it is organised as a market in the Netherlands, childcare is highly responsive to the private demand for childcare services (i.e. parents' value for money). This creates all kinds of uncertainties that are detrimental to the stability of childcare, which has adverse effects for both children and workers in childcare (Interview 1, 3). A manager director explains: "We should really take inspiration from the Scandinavian model, where everything is arranged much better." (Interview 3).
A second cultural obstacle is the 'mother myth'. As a nation with a strong Christian heritage, there is a strong ideal in the Netherlands that children are best cared for by their biological mothers rather than by professionals. This myth is so strong, that even pedagogical workers – 95% of whom is female – mostly prefer to work part-time and only three or four days a week (interview 1). This exacerbates the current staff-shortages in the sector, meaning for the organisation in this case study that it is sometimes very difficult to adhere to the stipulated professional-child ratio's (Interview 2). As the manager of 'Pact of child centres' recalls: "Many women work part-time in order to care for their children at home. It is ironic that [pedagogical workers] themselves maintain the 'mother myth."(Interview 1).
As stated, the child centre in this case study has formally two legal identities due to the split regulation and financing of education and childcare in the Netherlands (Interview 2). Formally, an educational organisation is not allowed to merge with a childcare organisation. The first is a public service, while the latter is a private enterprise (commercial or non-profit).

One way child centres deal with this is to set up an overarching organisation, with the same board members in both the educational and childcare branch. If you would not set up an overarching organisation, one organisation would have to pay 21% VAT on externally hiring the other's staff (Interview 1).
The organisation in this case study has dealt with this issue by setting up a double formal identity, with a single management and one back office support staff. Still, the locations themselves are integrated in various ways. Typically, locations start out with one or multiple managers for education and childcare separately. Experiences in the past have taught this organisation that, once there is a single management which is responsible for both education and care, equal collaboration and full integration of education and care become a real possibility (Interview 1).
A formal obstacle to equal collaboration between teachers and pedagogical workers are the different collective labour agreements for education and childcare (Interview 1, 2). To start with, there are marked differences in the level of financial remuneration between teachers in primary education and pedagogical workers. In the current collective labour agreement, pedagogical workers have a starting salary of 1,974 euro's based on a 36-hour workweek, which is relatively close to the minimum wage of 1,727 euro's (Cao Kinderopvang, 2022a; 2022b). Meanwhile, the starting salary of teachers in primary education is no less than 3.001 euro's based on a 40-hour workweek (Onderwijsloket, 2022).
In addition, the collective labour agreement of primary education has more finances and time available for the professionalisation of staff as compared to the labour agreement of childcare. The organisation solves this by offering the pedagogical workers the same budget (500 euro's per year) and similar opportunities as the teachers (Interview 3). A remaining issue when it comes to the professionalisation of staff is that primary education has a fixed number of 'study days' on which the schools are closed and teachers can attend conferences or follow courses. Such study days are not available in childcare, which is open year round. In some locations, this issue is solved by offering several 'study evenings' instead of a single study day. However, this still costs pedagogical workers their own time, while teacher's can study at a time they would otherwise be working. Unfortunately, closing a location for an entire day is often too expensive (Interview 2). Parents also expect childcare services to be offered all the time, since it is a service they pay for. This obstacle is thus yet to be resolved in the future. As a manager remarks: "The most logical solution would be that childcare goes public and that there will be a single collective labour agreement." (Interview 3).
Finally, an important factor facilitating the growth and proliferation of child centres are the changing societal attitudes towards childcare services. Illustrative are the reports of the Social Economic Council, in which childcare is no longer framed as a tool for the labour market participation of parents, but is also seen as beneficial for the development of children and the realization of equal opportunities in Dutch society (SER, 2016, 2022). In addition, the manager of 'Pact for child centres' sees the growth of academic pedagogical science tracks as another indicator of this development (Interview 1). The managers and staff of the child centre organisation in question recognize this development. However, they stress that the 'alternative' pedagogy such as 'Dalton' has always stressed the importance of early childhood education – not only in terms of qualifications but also socio-emotionally and psychologically (Interview 2, 6, 7). It may therefore not be very surprising that it were precisely schools of such alternative persuasions that started to offer the first (semi-integrated childcare services (Interview 1).

Case 2: Recruiting and retaining pedagogical (ECEC)

The case study context

In 2022 the social partners in 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 regarding the importance – and vulnerability – of social sectors. Expectations are that 135,000 (!) extra workers will be needed in the care sectors in 2031. The Social and Economic Council (SER) advises to expand hours of part-time workers (next to new labour market entrants and pensioners), raise the quality of work, implement technological and social innovation, combat the 'red tape' and provide long term perspectives in policy and financing (SER, 2021; SER, 2022). Where the SER has a function in agenda-setting, this case study is about how labour scarcity affects a childcare organisation and how an organisation deals with these challenges in practice.

Many Dutch childcare organisations struggle to attract and retain sufficient pedagogical staff members due to labour scarcity. Members of the employers' organisation BK typically use (a combination of) several measures aimed at improving the attractiveness of work in the sector. First, by innovating in the recruitment process itself. For example, by using novel ways of reaching out to job seekers. Second, by improving the working conditions or benefits for pedagogical workers – such as offering more contractual working hours. And finally by offering opportunities for professional development to pedagogical staff, thereby improving their career opportunities inside or outside the organisation (Interview 9). The childcare organisation central in this case study is exemplary, because it employs all three methods to recruit and retain sufficient staff members (Interview 10, 11, 12).

The organisation in this case study offers childcare services for children aged between 0 and 12 years old. For very young children, aged 0 to 4, the organisation has two daycares and two pre-school organisations spread across six locations. The largest part of their services concerns after-school care (BSO - *'buitenschoolse opvang'*), where children aged 4-12 who attend primary education can be taken care of during business hours after school hours (Organisation website). The organisation has initially started as a BSO-organisation, which explains why the largest part of their services fall in this domain. The daycare and pre-school locations have been acquired through mergers and business takeovers. Only at the largest location are all these services combined in one building. Generally, the daycare, pre-school and BSO are spread across several smaller locations close to primary schools. Since the organisation only operates within the municipality of Purmerend, all locations are relatively close to one another (Interview 10).

The organisation started with a single location, and has experienced quite rapid growth in the ten years of its existence (Interview 10). For the interviewees, it still 'feels' like a small organisation – in the sense that management personally knows all employees, and there is regular contact between the office and workers at the various locations (Interview 11,12). The organisation now has grown so much that, at the beginning of this year, it has introduced a new layer of management. A team of several 'cluster managers' now forms the linking pin between central management, and the managers of each of the daycare or BSO locations (Interview 10, 12). These cluster managers are mostly recruited from the pedagogical workers who have been working with the organisation since the beginning, although some are recruited externally (Interview 10, 12). Due to its growth, the organisation now has around 150 employees, but it will probably have around 200 employees in the near future (Interview 10).

A unique feature of the organisation is that sports instructors work alongside pedagogical workers in offering ECEC services to the children. The organisation is a family business set up by a couple with a background in sports education as well as pedagogical work (Interview 10). Sports is one of the central pillars of the pedagogical approach taken by this organisation, in addition to a focus on creativity, music and play (Organisation website). In fact, one of the motives behind the founding of the organisation was to offer more comprehensive labour contracts to sports instructors, since sports instructors often need to collect small labour contracts at multiple organisations to build up something resembling a full-time work week (Interview 10). The sports instructors primarily work at the BSO locations, as they lack the qualifications to work at the daycare or pre-school locations. In addition, they organize sport and play activities that children (and pedagogical workers) of the various locations can attend (Interview 11). Still, pedagogical workers make up the vast majority of the workforce and sports instructors make up roughly one-fifth of the workforce (Interview 10). As we will explain later, the collaboration with sports instructors contributes positively to the quality of work and services related to the pedagogical staff in several ways.

The issue

Staff shortages plague the Dutch ECEC sector (Interview 9) and are the reason why the organisation invests strongly in recruiting and retaining staff members. Because there is a lot of competition between daycare and BSO organisations for pedagogical workers, this organisation has elevated sending out the right vacancies at the right time to an art. Despite this, and the other innovations to be discussed later, the organisation still finds positions at the BSO particularly difficult to fill. This is largely due to the small and rather inconvenient working hours of after school care, generally between 2 and 5 p.m. (Interview 10).
Another issue in the sector to which the organisation responds are the generally small and fragmented contracts of pedagogical workers. It is typical for pedagogical workers in the Netherlands to work multiple jobs at multiple daycare, pre-school and after-school care providers. Working for multiple employers complicates the finances and administration of the household. Moreover, workers in the Netherlands receive a labour tax reduction for only one employer, which makes working for multiple employers financially less rewarding. In addition, combining daycare or pre-school with after-school care leads to 'broken shifts' and rather useless 'free time' in the afternoon (Interview 12).
Although pedagogical workers tend to gather small contracts at multiple organisations to fill their working week, another reason for the prevalence of part-time contracts in the sector has to do with the fact that the overwhelming majority of the workforce are women. Often, the organisation finds that women do not want to work more than three days per week. This because they want to set aside some time for their household and childcare duties at home. The Netherlands is characterized by a Christian child parenting culture where the mothers traditionally take full responsibility for raising their children at home. This harms the opportunities for professional development of these women, as – for example – certain management positions at the organisation require a working week of at least four days (Interview 10).
Finally, the 'corona crisis' has been a major challenge for this organisation, as for other ECEC organisations. The sector feared a sharp drop in the demand for ECEC services, due to the prevalence of working from home during and possibly after the crisis. Thus, many other daycare organisations have laid off or fired pedagogical workers during the early days of the crisis. However, the Dutch daycare sector was used as an instrument to protect the labour participation of parents during the lockdowns – through the so-called 'emergency daycare' [*noodopvang*]. And the early signs this organisation receives seem to indicate that the

demand for childcare services is precisely growing now that people work from home (Interview 10).
Organisations that laid off pedagogical workers during the crisis are now compelled to hire self-employed pedagogical workers to fill the gaps in their roster (Interview 11, 12). This creates several problems for these organisations. First, self-employed pedagogical workers are more expensive and less productive for management. Self-employed workers may ask an hourly rate that is almost double the rate of regular pedagogical workers. In addition, being temporary workers they are less familiar with processes and ways of working in the organisation. Second, self-employed pedagogical are less familiar with the children and their parents, and thus reduce the quality of services. Finally, hiring self-employed pedagogical workers creates inequalities and frictions within the workforce. Regular workers may feel unfairly treated, when they find that some unfamiliar colleague is paid almost twice their own rate while they contribute little to actually serving and schooling the children (Interview 11). However, this organisation has not laid off any staff during the corona crisis and is therefore not compelled to resort to externally hiring self-employed pedagogical (Interview 10, 12).

The process

The organisation management and staff recognize that the organisation is quite unaffected by current personnel shortages in the sector (Interview 9, 10, 11, 12). However, the organisation attributes a lot of its success in recruiting and retaining (pedagogical) workers less to recent innovations within the organisation than to the organisation's modus operandi. Thus, some of the 'innovations' central in these case have been its standards ways of working since its inception.
The organisation has been keenly aware of the value of good working conditions since its inception. As stated, one important motivation behind setting up the organisation was to be able to offer larger contracts to sports instructors. However, the organisation was not set up by the manager alone. Her partner was also involved. This partner has extensive experience in the Dutch ECEC sector and a keen sense of how things should *not* be organised. The organisation feels that some other childcare organisation may not realize the value of pedagogical staff. Many organisations may only consider that workers make up 80% of their costs in this sector, but this organisation fully embraces that the workers are the people who add value to its product. Two key things the organisation sought to improve were, first, the hire of sufficient pedagogical staff members and, second, the use of a personal management style rather than a controlling management style (Interview 10).
Both aspects have received attention since the start of the organisation. As an employee confided to us, one of the founders wants to visit all locations and meet their sports instructors and pedagogical staff personally (Interview 12). As stated, this organisation has managed to retain all staff members during the corona crisis. Remaining visible and open to staff members was challenging, due to the rapidly changing lockdown regulations. In order to motivate and inform pedagogical staff, management re-recreated the Dutch public news and presented it in a playful way (Interview 9).
The combination of sports and childcare, and the accompanying interprofessional collaboration between sports instructors and pedagogical workers has been a key characteristic of this organisation since it was founded (Interview 9, 10). The sports instructors work at all after-school care locations, and come up with daily sports games and exercises (Interview 12). The sports instructors are primarily concerned with group dynamics and children's physical development, while the pedagogical workers tend to focus on individual cognitive and emotional development (Interview 10). Thus, there is

interprofessional collaboration at all after-school care locations, which is valuable for both the workers themselves as well as the children (Interview 9).
Currently, the organisation is in a 'transition' from small to large organisation (Interview 11). On the one hand, this creates additional opportunities for the professional development of pedagogical workers. The organisation has recently set up a new layer of cluster managers, who act as intermediaries between central management and the location managers. Many of the long-serving pedagogical staff members have been promoted to these positions (Interview 10, 12). On the other hand, the growth of the organisation makes it increasingly difficult to retain its characteristic 'personal' approach to staff members (Interview 11). As contact between management and pedagogical workers decreases, understanding each other and taking each other's wants and needs into account may become more difficult (Interview 10). Thus, the cluster managers make sure that central management is still able to visit all locations personally (Interview 11).

The solution

One key outcome of the policies and practices described above is that the organisation's numbers of staff are generally well above what is required according to the 'professional-child ratio' (BKR). Hiring enough staff is beneficial for reducing working pressure. Yet, it also adds to the opportunities for professional development in the organisation (Interview 12). For example, the organisation has recently set up an internal educational track for childcare (assistant) manager – which has attracted both internal and extern students (Interview 10, 11). Because there are sufficient pedagogical workers to attend to all the children and perform additional duties (such as paperwork), people who are in training can have short internal 'internships'. They can take over tasks, such as planning or recruitment of new staff, on a voluntary basis. Due to the presence of sufficient personnel, they supplement rather than replace the regular workforce (interview 12).
The personal rather than directive management style also has positive outcomes for the quality of work. Such a personal approach makes people feel seen and valued (Interview 11), but also heard. When for example a new location opens, managers will personally speak to several pedagogical staff members they have in mind for that location three months in advance. And these conversations are based on the wants and needs of the staff members first, and the organisation second (Interview 10). In addition, people also have a greater say in their working hours. Because the organisations hires sufficient staff, pedagogical workers who want to take paid time off or call in sick do not have to feel guilty towards their colleagues, as may be the case at other organisations. Conversely, pedagogical workers who want to work a few extra hours can always raise this and their requests are often granted (Interview 12).
The collaboration between sports instructors and pedagogical workers creates a more diverse working environment for both (Interview 12). In addition, sports instructors tend to be male while pedagogical workers are overwhelmingly female. This also adds social diversity to the workforce, as men and women can mingle and collaborate. In addition, the additional sports activities and the presence of both male and female role models are also beneficial for the children themselves (Interview 11).
Importantly, the combination of sports and childcare helps the organisation to offer full working days to pedagogical workers. Pedagogical workers who combine daycare or pre-school with after school care at other organisations, often have to deal with a 'split shift' resulting in 'useless' free time in the afternoon. However, the sports instructors of this organisation often organize sports activities in precisely these hours. Pedagogical workers regularly help at these activities, in order to get paid a full working day and diversify their

activities. In addition, this organisation also pays pedagogical workers who transport children from and to locations or schools in the area – which often happens in the afternoon as well (Interview 12). Although it goes too far to say that the presence of sports instructors helps to attract pedagogical workers directly, according to the people we spoke to their presence definitely benefits both the quality of work for pedagogical workers as well as the quality of services for the children (Interview 10, 11, 12).

The implementation

As stated, some of the good outcomes in this case concerning the quality of work amongst pedagogical staff are not achieved by 'innovations' as such. In fact, the manager considers the 'old-fashioned' modus operandi as key to the success of this otherwise 'young organisation'. These old-fashioned ways of working are present, first, in the 'formation management' employed by the organisation. A complete personnel planning is made three years in advance, which contains predictions about where the organisation expects to grow and how many employees of which type it will need. This gives sufficient time to recruit new staff members, or discuss opportunities for relocation with current staff members well in advance (Interview 10). This forward planning allows the organisation to hire newly recruited pedagogical workers one month before their full duties begin. This way, new workers are able to 'ease into it' and do not have to know and do everything right from the start (Interview 12).

Secondly, the organisation goes against current post-corona trends in the uptake of working from home. Instead, the organisation has an 'old fashioned' office culture of in- person meetings. Requiring office workers to be present, decreases the differences between them and the pedagogical workers and sports instructors. After all, children cannot be taken care off through a screen. In addition, the actual presence of office staff and the frequent meetings between central, middle and location management have the effect that management keeps 'in touch with' the executive staff (Interview 10).

One possibly more innovative, or at least less 'old school' aspect of this case may be that the organisation has refined 'the art of sending out smart vacancies at the right time'. First, the timing needs to be just right. There is no point in reaching out to students who are about to finish their education in sports instruction or pedagogical work, the founders know from their own experience how intensive the final stretch of these educational tracks can be. In addition, many students travel immediately after graduating, making the best time to reach out to them well beyond their graduation date. Second, the recruiting and working conditions have to fit the wants and needs of the new generation. The founders both regularly visit educational institutions of sports instruction and pedagogy. While giving lectures as both experienced practitioners in their fields, they take the opportunity to chat with students and ask them how they imagine their futures (Interview 10). This is where the idea for a 'low stakes' initial working period, where people are hired one month before their actual job begins (Interview 11), came from. As the founders found that the younger generations are more hesitant to take on responsibilities. In their own words: 'Younger generations are part of the Netflix culture: they first want to get a taste for things, without too much commitment right away.' (Interview 10).

The collaboration between sports instructors and pedagogical staff is one of the unique selling points of this organisation, and possibly its most innovative aspect (Interview 10). This offers a uniquely diverse working environment in terms of tasks (Interview 12), as well as gender (Interview 11) for pedagogical workers compared to other organisations. Moreover, because the sports instructors organize afternoon sports activities in which the pedagogical workers are involved, they create a unique opportunity to increase the number of working

hours of pedagogical workers (Interview 12). The inclusion of sports also improves the organisation's collaborative relations with the local municipality, schools and sports organisations. For example, the sports instructors often visit the local schools to give sports lessons. And the municipality is 'very enthusiastic' about the role sports can play in creating more vibrant and resilient local communities (Interview 10).

Finally, luck also plays a role in this case. Another important factor which may explain the success of this organisation lies in its location (Interview 10). Purmerend is in the northern metropolitan part of the Netherlands, near Amsterdam. It is a fast-growing medium-sized city with 82,683 registered residents in 2021, and 92,240 registered residents in 2022 (CBS.nl, 2022), representing a growth of 11.6%. It is a popular but still relatively affordable place to settle, especially considering its vicinity to the capital. This allows pedagogical workers (and sports instructors) to live near the locations where they work, in contrast to many other newly built neighbourhoods in the Netherlands (Interview 10).

Case 3: Regionalisation in home-based care (LTC)

The case study context

The RP in this case study is located in the eastern part of the Netherlands, outside the metropolitan area. It was founded in 2017 for the purpose of combining the expertise and resources of the collaborating municipalities with a view to jointly professionalizing the procurement of care services in the region (Interview 13, 16, 18). The eleven municipalities cooperating in this partnership range from small villages to medium-sized cities. To give a sense of its scope, the number of residents in each of these municipalities is outlined below:

Municipality	**Number of residents**
Arnhem	163,888
Doesburg	11,064 (2021)
Duiven	24,958
Lingewaard	46,936
Overbetuwe	48,266
Renkum	31,358
Rheden	43,476
Rozendaal	1,753
Wageningen	39,939
Westervoort	14,943
Zevenaar	44,645
Total	471,226

Source: StatLine CBS (Statistics Netherlands

In total, the RP has to procure care services for almost half a million residents living in its area. The decentralisation of care services means that the municipalities remain the prime 'client' of the care providers in the region. The RP functions as a contract manager, an added factor in the relationship between municipality and supplier (Interviews 13,14,16,17,18). The municipality and the suppliers maintain their direct contact and the RP does not act as a gatekeeper standing 'between' them.
For example, access to home-based care is still organized at the municipal level. Local teams of 'access workers' link clients to the right providers. What this access looks like varies per municipality (Interview 13). The smaller municipality included in the case study works with a central 'care desk' where residents can apply for care services. The level and type of care they need are determined in direct conversations between the residents and the care suppliers (Interview 18). In contrast, the larger municipality has teams of social workers in each neighbourhood who visit residents who have applied for (home-based) care services. Together with the resident, they determine the type of care required and link the client to an appropriate supplier (Interview 16, 17).
Home-based care is procured by the regional organisation on behalf of the collaborating municipalities (Interview 13, 14). Three 'care products' define the units and quantity of home-based care services bought by the RP:

1) General domestic help: Clients need help in carrying out all or part of the household tasks. Clients are able to supervise the care worker and manage the service themselves. (RP, 2022, 3).

2) Customized domestic help: Household support is intended for people who live at home with some form of limitation (in accordance with the Wmo 2015). The extent to which a client is able to cope with his disability determines what help is offered. An important question here is also to what extent the client is capable of self-direction, can still learn how to deal with his limitations in combination with performing household tasks. (ibid.; 6)
3) Combi support at home: Intended for situations where domestic help alone is no longer sufficient. Combi support at home is a combination of customized domestic help and care given by one care provider creates the integrated range of Combi-support at home (ibid., 8). Typical care giving in this case refers to help in performing personal hygiene or self-care, such as brushing one's teeth, showering and bathing, or preparing and eating a personal meal (Interview 19, 20).

As stated in the previous chapters, social dialogue is centralized in the Netherlands and the social partners play no direct role in this RP. However, in line with the Dutch 'polder' model of ongoing consultations between stakeholders, the RP, municipalities and care providers have a regular formal dialogue and meetings through regional 'market consultations'. These consultations are organized multiple times per year and discuss shared problems that affect the RP, municipalities and providers – such as the limited budgets for care services or personnel shortages. Such a consultation can take place at the initiative of the RP, but also at the request of the municipalities or care providers (Interview 13, 14, 16, 18, 19, 20, 21). There is also a formal link between social partners and stakeholders at the local level: service providers must follow the collective agreement at sectoral level regarding wages and other terms and conditions of employment in homecare (negotiated by the employers' associations ActiZ and Zorgthuisnl and trade unions FNV, CNV, NU '91 an FBZ).[26] Municipalities are supposed to calculate 'real prices', based on the labour costs according to the most recent collective agreement. The budgets for municipalities for homecare are based on national regulations from the government.

The issue

The issue at stake at the RP is the professionalisation of procurement of home-based care services. While the RP was set up in 2017, its early years were still characterized by having to manage an 'unmanageable' number of care providers, many of whom were suspected to be 'care cowboys' (Interview 13, 16, 17, 18). In the initial period of the RP, between 2017 and 2019, there were no less than 700 to 900 providers active in the region. With such a large number of providers, it becomes very difficult for the RP or the municipalities to retain oversight and control of the quality of services in the region (Interview 14, 16, 17). The innovations discussed below were introduced in 2019 after a revision of the procurement procedure (Interview 13, 14, 15).
It should be noted that 'care cowboys' is a pejorative term, and neither the RP nor the municipalities wish to refer to specific suppliers in this manner. However, an employee of the largest municipality explained that it was clear that 'something had to be done' about the quality of care services in the region (Interview 16, 17). One key way in which such organisations are detrimental to the quality of both service and working conditions is their deployment of underqualified staff for specialized home-care services to reduce personnel costs. This is detrimental to the quality of the service, since underqualified personnel cannot

[26] See chapters 4 and 5 in part I of this report.

be expected to provide such a specialized service. Yet, it is also harmful for the working conditions, since such employees may get a lower level of remuneration than they otherwise would have had (Interview 15, 16, 17).
Another way in which organisations may want to reduce personnel costs is by constantly hiring new employees after a few years. After all, according to the collective labour agreement, wages of employees rise significantly in the first five years, after which they remain relatively stable. So it is much cheaper for care providers to lay off workers after two or three years and simply hire new ones. However, this is detrimental to the workers themselves as they constantly have to find new sources of income, but also to the clients who may have become accustomed to receive these very personal services from someone they know and trust. Especially trade unions are against the too insecure and extremely flexible jobs in the care sectors in the Netherlands. Finally, some organisations even violate the collective labour agreement by not reimbursing travel costs for workers in home-based care (Interview 20). These practises undermine the position of the social partners in the sector. Further, also the Ministry of Social Affairs and Employment launched in 2021 a campaign regarding better implementation of collective agreements and professional standards to enhance 'fair, healthy an safe working in homecare' in the Netherlands.[27]

The process

The RP in this case study was set up in 2017 by the collaborating municipalities. The objective was to enable the municipalities to bundle their expertise and other resources and professionalize their roles of clients in 'the social domain' – which refers to care services that are privatized in the Netherlands, such as home-based care falling under de social support act (Interview 13, 15, 16, 17). Since its inception, this RP has been using a regular open house procurement method, meaning that new providers can register every day if they meet the requirements set by the municipalities (Interview 16, 17). In practice this means that care providers that wish to register can indicate on an online dashboard in which of the participating municipalities they want to offer their services. The registering process and the supervision of care organisations is managed by the regional organisation (more on which will be detailed later), while registered care organisations thus also enter into a client-patron relationship with the municipalities they have selected (Interview 19, 20, 21).
The regional organisation sees two main advantages in using the open house procedure as compared to procurement using the alternative public tendering process. First, the region and its municipalities do not become dependent upon a select number of suppliers, but the number of suppliers can fluctuate during the contracting period (Interview 13, 14). A large provider describes these fluctuations as a 'wave' pattern: at the beginning of each new contract period, there are many new, small providers that do not make it to the end of the period (Interview 19). Secondly, a tendering process does not allow changes or termination of contracts within the contract period. Any substantial change would require a new procedure. In contrast, procurement through an open house process is beneficial for the continuity of services as contracts with specific suppliers can be changed in the interim period (Interview 14). In addition, individual contracts with care providers that have not had any clients of a particular service in a particular area for more than a whole year, can be and are automatically terminated - specifically for the service and area in question (Interview 16, 17).
In 2019, the RP started a revision of its procurement method, which has led to the birth of a 'semi' open house procedure on the one hand, and more stringent requirements on care

[27] Eerlijk, gezond en veilig werk in de thuiszorg een handreiking aan gemeenten als opdrachtgever in het sociaal domein (vng.nl)

providers following the development of an integrated quality control and enforcement framework on the other (Interview 13, 14, 16, 17, 18).
The 'semi' open house procedure was developed following a consultation with client councils, municipalities and providers. The 'semi' refers to the limited registration period the RP uses: in principle, further registrations of new providers are not accepted after a specific deadline. This decision met with resistance from some care providers, especially smaller organisations which did not have the human resources to adhere to the strict deadline (Interview 13). It even occurred that small organisations, in an attempt at defiance, tried to register after the deadline anyway. But this was simply 'impossible' (Interview 16, 17).
The integrated quality control and enforcement framework was the outcome of 'Project Quality', which was carried out from late 2018 to early 2019 by two working groups, each consisting of employees from municipalities and healthcare providers from the region. One of these working groups was concerned with the formulation and specification of quality requirements, while the other working group was concerned with developing an integrated control and enforcement framework (Interview 13, 14).
In sum, the end of the first decade of the 21st century can be characterized as a period in which the blind trust in the providers of home-based care services was gone. As an employee of a large municipality explains: "In the decentralization process, high trust, high penalty has also been chosen here in the region. [..] In principle it was: we assume that everything is going well. But due to the many publications about care cowboys, that naivety is a bit gone." (Interview 16).

The solution

The introduction of the 'semi' open house procedure is innovative in itself, since it is a novel way to organize open house procurement (Interview 13). However, it is also innovative due to its significant effects on the number of care providers in the region. Together with more stringent requirements on providers, the introduction of the 'semi' open house procedure led to a sharp reduction in the number of providers: from 700-900 in 2017-2019, to around 300 or 400 providers (Interview 16, 17).
The regional procurement organisation itself, as well as the larger municipality, welcome this reduction because the previous numbers of suppliers were considered too high to be properly manageable (Interview 13, 16, 17). However, it should be noted that small municipalities occasionally worry that they retain too few care providers in their area – making them highly dependent on whoever happens to be left (Interview 18). To illustrate, the number of care organisations providing 'general home care' – which is one of the three 'care products' defined in the region – varies from 19 in the largest municipality to a mere 10 in the smallest municipality (RP website).
In order to ensure that the reduction in the number of suppliers of care services does not have the effect that local demand cannot be met, the 'semi' open house procedure can also be opened for a specific service in a specific area (Interview 13, 14). For example, if there is a shortage of a particular type of home-based care in a particular area within a particular municipality, the first step is to contact all the suppliers active in that municipality. If these organisation are not in a position to provide these services, then 'the market will be opened for as short a period as possible'. In that case, the procurement process is opened temporarily, which may be a week, a day or even as short as a few hours (Interview 16, 17).
The second innovation in this case is comprised of two parts, aligning with the two working groups of 'Project Quality'. First, more extensive quality requirements on providers. Second, the integrated control and enforcement framework. The whole framework counts too many

requirements to discuss here in great detail. However, the most relevant requirements regarding the quality of services and working conditions are the following (Interview 15):

- The care providers are required to submit a 'care or treatment plan', which has been discussed with the client (or his representative), before they are allowed to provide any services to a particular client.
- The care providers are required to evaluate the 'care or treatment plan' together with the client at least six weeks before the care service ends
- The care providers are required to be adequately skilled and qualified themselves, or employ staff who are demonstrably adequately skilled and qualified to offer the procured services
- The care provider is required to minimize the number of care workers involved in providing the care services to a particular client. The ideal is to have one fixed care worker for each client, who is able to provide all relevant services

Considering that the 'care cowboys' issue was in large part about the employment of underqualified and underpaid staff in general, the new requirements include more specific requirements on the educational background of the care workers. Before 2019, it was only specified that workers should have completed a secondary vocational education or a track at a university of applied sciences. The new requirements specify that the care provider themselves and/or their employees should have completed a relevant education in the health sector. In addition, only a certain percentage of workers may be unpaid volunteers or interns – and these must always work under the responsibility of paid staff (Interview 15).

The requirement of having one fixed caretaker for each client is primarily set from the perspective of the clients themselves. Having care workers in your home and sometimes even during intimate moments such as washing or feeding yourself can be stressful, and it is better if it is someone you know and trust. However, the regional organisation and municipalities also recognize the requirement's benefits for the workers themselves, since it also implies that workers have – as much as possible – a fixed portfolio of clients. This makes their work more stable, and enables them to build positive and trusting relationships with clients (Interview 16, 17, 20).

At the same time, the ideal of having one fixed care worker for each client is not always realistic. Due to the current staff shortages, it is especially challenging to uphold this ideal during the summer holiday period (lasting from June to August). Therefore, at the initiative of the regional organisation, the municipalities together with the care providers in the region sent letters to their residents/clients in the summer of 2022 that they could not guarantee that all clients would receive the regular number of hours from their regular care worker during the summer months (Interview 16, 17, 20, 21).

Moving on to the second outcome of 'Project Quality', the main innovative feature of the quality control and enforcement framework is the integration of preventive and repressive measures (Interview 15).

One key preventive measure of the framework is the 'validation conversation'. Employees of the regional organisation have in-person talks with prospective suppliers of care services in the region. During this conversation, the quality criteria are discussed and the prospective supplier must show to the regional organisation that it demonstrably meets all criteria. Care providers who do not convince the regional organisation that they meet all criteria are not 'validated' and not allowed to offer their services in the municipalities in the region (Interview 15).

A second key preventive measure employed by the RP in question is the use of quick scans. For example, the larger care organisation we spoke to was subjected to two quick scans since

2019 (Interview 18). If this quick scan leads to the suspicion that some quality criteria are not met, the regional organisation escalates to more repressive measures (Interview 15).
The repressive measure mainly consist of maintaining oversight, in large part through 'signal conversations' with suppliers. Such signals may come from the aforementioned quick scan, but workers or clients can also send signals directly to the regional organisation via a 'signal button' on its website (Interview 14, 15). In such a 'signal conversation', the relevant signals are discussed between employees of the regional organisation, employees of the municipality where the signal originated and a representative of the care organisation in question (Interview 15).
If the care provider is unable to remove all doubts after a 'signal conversation', the signal will be raised at the regional signal meeting, which is held once per month and is attended by employees of all collaborating municipalities. This way, signals concerning a particular care provider can be accumulated and it can be examined whether the signals are mere incidents or reflect a structural issue (Interview 15). In addition, the regional organisation itself carries out 'signal analyses' twice per year, where it makes in inventory of all signals pertaining to all care providers (Interview 16, 17).
The most common signal received by the regional organisation is that care providers have failed to provide an adequate 'care or treatment plan' before starting their service delivery to the client. Especially small organisations may have trouble producing the required paperwork and also getting the plan discussed with and signed by a (representative of) the clients themselves. A second common signal is that organisations use underqualified staff to provide particular services. Sometimes these signals are 'clear as day', for example when an employee gets hired based on 'life experience'. In such cases, signals may even lead the regional organisation to demand refunds from the care provider. In other cases, the qualified or unqualified nature of the worker may be (much) less clear. For example when a doctor's assistant is employed to provide home-based care. In these cases, the employee does have the necessary skills to provide the service, and the provider may only be reprimanded and required to make sure that the employee also acquires the relevant qualifications in the near future (Interview 15).
Considering the extensive quality criteria and the intensive oversight organised by the regional organisation, it is likely that these innovations have improved the quality of services in the region and – indirectly – also improved the quality of working conditions by ensuring qualified and paid employees work as much as possible with fixed clients (Interview 13, 14, 15, 16, 17, 18, 19, 20, 21). However, there is one caveat: not every municipality is equally active in picking up signals about providers active in their area. As an employee of the regional organisation explained: "Arnhem is sky high at the top. And the rest gives one or two signals per year. That is a really big difference. There is work to be done. [..] Some municipalities never submit a signal. That cannot be true." (Interview 15).
One important reason for the variation in the reporting of signals between municipalities is the diversity in the knowledge and skills of the access workers employed by the municipalities (Interview 14). This while precisely the access workers are the 'eyes and ears' of the municipality when it comes to signals regarding the quality of services or working conditions (Interview 18). For example, access workers are not always aware that they must receive a fully detailed care and treatment plan before the care organisation can even start providing care, or they may refer a client to an organisation with insufficiently qualified staff because they do not know how to check the personnel administration (Interview 15).

4.5: The implementation

A first very important success factor for the switch to 'semi'-open house, raising and expanding the quality requirements and setting up the control and enforcement system was the widely felt need to tackle the issue of 'care cowboys'. At the end of the first decade of the

21st century, there was a perception, both in local politics and in government, that there were too many providers 'who are cutting corners and want to earn money quickly'. These healthcare cowboys were seen as 'bad apples' that affected healthcare across the region. It was widely felt that the quality requirements had to be raised and that it was acceptable if this would lead to fewer providers (Interview 13, 15, 16, 17).

A second important success factor is the pioneering role of the largest municipality in the regional collaboration. For example, this municipality has been very important in developing the 'semi'-open house procurement method (Interview 13). In addition, this municipality is actively pursuing various pilots to increase the quality of services and to professionalise the partnership itself. For example, the municipality is currently working on establishing a regional pool of supervisors to improve the enforcement framework discussed above. At the time of writing, the staff responsible for the preventive and repressive measures detailed in the enforcement framework is largely provided by the municipalities themselves. However, while some municipalities can easily provide multiple full-time supervisors, others have to make do with one part-time position – simply due to the varying size of their organisations. Having one regional pool of supervisors should eliminate this disparity in the future (Interview 16, 17).

An important obstacle in this case are the limited possibilities and resources of (some) municipalities. The decentralisation of care services in the Netherlands was accompanied by budget cuts, making the resources of all municipalities quite limited (Interview 13, 14, 15). However, the resources of some municipalities are more restricted than others, resulting in – for example – the variation in the quantity and quality of 'access workers' mentioned above (Interview 15, 16, 17, 18). In addition to having limited finances, municipalities also face with more or less challenging local 'markets'. Especially more rural and smaller municipalities face a relatively high demand for care services due to an ageing population, together with a relatively low supply in the size and number of providers they have at their disposal (Interview 16, 17, 18). This means that the bigger cities can more easily enforce restrictions and terminate contracts with suppliers than municipalities covering smaller villages (Interview 16, 17). The regional organisation cannot erase this individual variation nor should it necessarily do so. Some municipalities are of the opinion that the (additional) integration this requires is not always worth the effort, or they opine that certain forms of care giving should in principle be fully managed by municipalities themselves or the market itself (Interview 15, 16, 17). Municipalities may also fear losing their autonomy or specific 'political colour' (Interview 19). In short, this means that the obstacle posed by the contingencies of local 'markets' of care services is not completely overcome.

A final obstacle is the historical and ongoing resistance of care providers against the increased quality requirements or intensified enforcement and control mechanisms. Ultimately, the region managed to convince the (remaining) providers that these requirements are simply necessary, because they can only terminate the contract with a 'provider who misbehaves' on demonstrable grounds. However, resistance from providers to control measures is persistent. Often, a 'tug-of-war' arises over information which is requested by the RP because providers have the idea that the organisation wants 'confidential information'. This while the region only needs to know 'in abstract terms' how the service is doing, without personal details of clients (Interview 14, 15).

Case 4: self-organising teams in a nursing home

The case study context

The organisation currently works from three buildings (organisation website), in which around 400 professionals care for the mostly elderly clients (Interview 24). Residential care is the 'core business' of this relatively small organisation, although it also employs three teams of homecare workers (Interview 25).
The oldest residential care location was built in 1936 by reformed deacons. In the eighties, every two rooms got their own shower and toilet – reducing the number of spots available from 135 to 85. In order to make up for this reduction, around 100 sheltered houses built during the eighties and nineties (Organisation website).
Another location was constructed by 10 Mennonite church communities, initially having room for around 77 residential clients and 16 sheltered housing units. In the nineties and the early 21st century, 100 sheltered housing units were added. Both the oldest location as well as this location were renovated in 2008, in the course of which some apartments were transformed into group homes (Organisation website).
The most recent building was constructed in 2015. It was constructed based on collaboration with the local neighbourhood. This building is somewhat smaller, and contains four group houses (organisation website). Unfortunately, the construction process of this building was delayed – making it more costly than anticipated. This was a blow for the finances of the organisation (Interview 23), which are already quite limited. The organisation is financed through fixed tariffs based on the quantity and intensity of care. These funds are acquired from various sources, such as so-called 'care offices', subsidies and insurance companies (see part I). They amount to around 250-300 euro's per client, per day (Interview 24).
The nineties were in the Netherlands the heydays of neoliberalism and 'third way' socialism (De Jong, 2013). The Dutch care sector is marked by many closures and mergers of smaller organisations, with the aim to survive on the 'free market'. The two locations were separate organisations back then, but they merged with each other to prevent having to merge with surrounding, larger and more commercial organisations (Organisation website, Interview 24). The current organisation is thus already quite small (Interview 23, 24, 25), but has emerged from a merger of two even smaller organisations.
The social partners in the LTC sector in the Netherlands are interested in more information about experiences in the field and the further spread of best practices with self-organising teams and new leadership and management structures in the sector.[28] Problems of low professional autonomy in the sector are recognised (Part I of this report).

The issue

The organisation has started to implement self-organising teams with the arrival of a new director in 2016 (Interview 23, 24). One of the main reasons for implementing self-organisation was the desire to improve the autonomy of care professionals in the organisation. The new director explains that on arrival, he found the organisation to be quite hierarchical. In his words: 'At the time, there were two locations. Both locations had their own location manager. In addition, there was a manager for every policy area you can think of: a financial manager, a facility manager, a human resource manager.' (Interview 24).

[28] Wie is de baas? Dubbelportret in de VVT (aovvt.nl)

With the step from a hierarchical to a self-organising organisation, the organisation became 'flat'. Currently, there is only one central management with the self-organising teams right directly under it (Interview 24). In total seven mid-level managers lost their jobs (Interview 23, 24) And even though the introduction of self-organising teams was accompanied by lay-offs, management stressed that was explicitly not intended as a cost-cutting measure. The fact that the organisation has not 'given up' on implementing self-organising teams, and instead pursues social and technical innovation, is precisely because management cares about increasing the welfare and autonomy of their care professionals (Interview 24).
In addition, the 'path towards self-organisation' was taken in order to guarantee a good quality of service. As a manager explains: 'Who can better decide what type of care a client needs than the caretaker herself?' The care professionals are in direct contact with the client and their families. They know the context in which the current issues have arisen and in which care has to take place. This makes them especially suited to identify and address the needs of the clients (Interview 24). One of the coaches mentions that – despite all the social innovation going on when it comes to self-organisation – the client ratings of the organisation are quite stable around 8.5/10 points (Interview 25).
A final issue to which self-organisation responds is the staff shortage in the sector. These staff shortages are exacerbated by the ageing of the population – which increases the quantity and intensity of the required care (Interview 24). Moreover, in the Netherlands, there is a trend towards homecare. As the coach – who has a long career as a care professional – explains: 'Everyone wants or has to stay at home as long as possible. This has the effect that the situation has already become more challenging by the time a client arrives at our doorstep.' (Interview 25). Management notes that there is a limit to the number of care workers you can recruit to solve these issues. Dealing with the staff shortages – which are becoming more permanent – also means investing in social and technological innovation to increase the quality and skills of staff (Interview 24).
Another factor contributing to staff shortages in this particular organisation is that potential staff members leave to work for neighbouring larger competitors, which can offer professional development tracks and career opportunities to new staff members that the small and relatively 'flat' foundation cannot offer (Interview 23, 24). However, its 'flat' character is precisely a feature of the organisation that management would like to retain, since it is in such a context that self-organisation of professional care teams can flourish and the autonomy of care professional can be guaranteed (Interview 24, 25).

The process

As stated, self-organisation was introduced by the new director when he took office in 2016. In order to get to know the organisation and its staff, he first took an 'internship' position with the old director for half a year. This old director has led the organisation for close to 40 years, and had been a care professional before that. In contrast, the new director was relatively inexperienced in the sector (Interview 23).
The drive to implement self-organisation came from the idea that the current organisation was too hierarchical, and care professionals had too little autonomy (Interview 24). In the staff meeting where the move towards self-organisation was announced, many care workers responded enthusiastically. They looked forward to getting a bigger say in their planning or in the recruitment of new colleagues. Nevertheless, some of the, mostly experienced, colleagues immediately saw a problem: 'Does this mean we will also have to organise our own procurement and finances? Yes, it does!' (Interview 23). The resistance from care workers who are 'more accustomed' to the more 'directive' style of management is something we will return to later (Interview 24, 25).

From the outset, the organisation has worked with self-organising rather than self-managing teams. In the words of the manager of business operations: ‘‘The arrow which points north, that is management. We are at the rudder. But how we get in the boat, that is up to the employees themselves.’ (Interview 24). In short: the ‘*where to?’* and ‘*why?’* has always been up to management, while the employees answer the ‘*who?’*, *where?*, ‘*what?’* and ‘*how?*’.
Initially, there was some resistance in the works council to the implementation of self-organisation. Some worker representatives felt that it could add to the work load of the already heavily burdened care professionals if too many tasks would be delegated when too little support structures were in place. There critical remarks were mainly made by the employee representatives who are a member of the largest general union of the Netherlands – the FNV. The FNV union has also organised a meeting at the organisation to discuss the grievances of staff members with regard to the implementation of self-organising teams (more on these grievances later). In contrast, the works council representatives who are members of the smaller union Nu’91 were more welcoming and less critical of the implementation of self-organisation (Interview 23).
In 2016, self-organisation was first applied in homecare (Interview 23, 25). This was the most logical starting place, since care workers in home care are already quite independent (Interview 24). Nurses and other professionals in homecare work on their own most of the time, seeing their colleagues during coffee breaks or other get-togethers. Only some very demanding tasks require direct collaboration between two homecare professionals (Interview 25). In addition, homecare workers are already used to working with certain management tools, such as ‘billable hours’ and ‘workflow’ (Interview 24).
The implementation of self-organisation in homecare was a success, and all three homecare teams of the organisation were symbolically ‘given the key’ by management. This is like a diploma in self-organisation (Interview 25). Following this success, self-organising teams were implemented in residential care starting in 2018. Some modifications were made to make this concept applicable to residential care. Within each of the self-organising teams, also in homecare, there are two designated ‘team roles’: First, a ‘team member planning and personnel’, this care worker carries the primary responsibility for the planning and rostering of shifts, as well as the recruitment of new staff within the team. Second, a ‘team member finances and facilities’, who arranges the budget and procurement of materials the team needs. However, unlike in homecare, the self-organising teams in residential care also have a designated ‘quality nurse’. This position was added because the residential care sector in the Netherlands is very strictly controlled and audited, by the insurance companies but also by the municipal health services. The quality nurse is there to make sure everything happens according to designated protocols and meets these external criteria (Interview 24).
Still, in hindsight, the implementation of self-organising teams in residential care was initially too much based on the model in homecare. Care professionals experienced a lack of support and motivation to self-organise (Interview 23). There was not a clear ‘ownership’ of the process amongst care professionals. In addition, the rules and regulations were too unclear back then. This led to a situation that the processes and conditions of self-organisation varied from team to team. Different teams of care professionals had different ideas about what self-organising meant in practice, as well as about what it should mean (Interview 25). In 2019, management organized a ‘revival’ of self-organising teams: the concept should clarified and more support structures were needed to allow residential care workers to self-organise (Interview 24).
The approach to self-organisation was further developed with support from the ‘Dignity and Pride’ program, initiated by the Ministry of Social Affairs and Employment (Interview 24). This program was launched in 2019, and sought to combine insights gained from research and practice to improve the quality of work and quality of service in the sector. Over 500

homecare organisations participate in this program, which covers no less than 23 themes, such as 'methodical working', 'the future of homecare', 'fun at work' and 'vitality at work' (Waardigheidentrots.nl, 2022). One of the main lessons this organisation has learned from this program is the importance of a 'flat organisation' – which helped the 'revival' of self-organisation in 2019-2020 (Interview 24).

Two key innovations shaped the new approach to self-organisation: improving the support structure and improving the role of central management. To start with the first, the organisation has attracted 'coaches' to support the teams in carrying out the more difficult tasks of self-organisation (Interview 24, 25). For example, there is a coach 'facilities and finances' and a coach 'personnel and organisation'. These coaches help – for example – with drafting the yearly budgets, which is an especially challenging task for care professionals (Interview 23, 25). In total, there are three coaches for the 21 teams in residential care (Interview 25). These coaches replaced the previous 'team leaders' – which were the linking pin between the teams and management (Interview 24, 25).

Unlike the team leaders before them, the coaches also support group cohesion and other group processes in addition to offering guidance in carrying out more difficult tasks. The composition of teams turned out to matter a great deal when it came to the success of self-organisation (Interview 24). For example, the different levels of education may matter a lot. Within the organisation, and within the teams, people from various levels of educational attainment work together. Dutch secondary vocational training is divided into four levels. There is a 'level one residential support worker, a level two and three helper position, as well as 'individual caretaker' – which is a level four position just like the 'quality nurse'. In the experience of one of the coaches, higher educated staff members are more proactive in taking up organising tasks and have less difficulties carrying them out. The coach is there to make sure no one feels left behind and everyone carries their responsibilities (Interview 25).

In addition to this social innovation, the improved support structure also makes use of technological innovation (Interview 23, 24). The organisation has acquired several apps to allow care professionals to do organizing tasks on their phone, which is automatically connected to their personal computer. For example, there is an app where care workers can submit their preferred worktimes in a roster, or an app with which they can scan the groceries they do for their clients (Interview 23).

Moving on, the role of central management has changed in the sense that some tasks which were previously fully the responsibility of the teams are now coordinated by management. This is primarily the case when it comes to the planning of shifts, and the recruitment of new staff. With regard to planning, management found that when this was left entirely to the teams, unfair situations can arise. For example, the team member responsible for planning may grant some people their wishes and deny the wishes of others, based on 'wheeling and dealing'. This is an unfortunate consequence of the fact that there is always a 'directive' element to planning: 'Sometimes it is necessary to say to people: "I am sorry, but you are going to have to work that day." And then it is better if the message comes from management instead of from one of your colleagues" (Interview 24). In addition, the central coordination of planning is also important to make sure that all the rosters of the individual teams fit together and there are always sufficient staff members present (Interview 24).

Recruitment is also centrally coordinated. The teams of care professionals attract and recruit new staff members – for example through word of mouth or by posting vacancies in nearby supermarkets – but the 'new recruits' they propose are ultimately interviewed and hired by management (Interview 23). This is so because management wants to employ strategic personnel planning: what kind of workforce do we need in several years? For example, people who are able to work with all the coming technological innovations such as the increasing introduction of A.I. in residential care (Interview 25).

Getting the entire workforce to embrace the idea of self-organisation and become familiar with its practices is a long process. Currently, around 30% to 40% of the employees has 'fully internalised' self-organisation. They actively seek out and talk with management, and they can 'talk on the same level' about – for example – strategic, tactical as well as operational affairs. Of the 400 employees in total, around 100 to 150 are such 'active and involved' care professionals (Interview 24).
As stated, one obstacle to self-organisation in residential care compared to home care is the generally lower level of education of the staff. Homecare workers tend to be level three or four, while care professionals in residential care are generally educated at level two or three. Moreover, the composition of the teams in terms of educational attainment may vary, and teams with a lower level of education tend to be less proactive and involved. This may due to the more 'directive' style of teaching at lower vocational training schools. As the coach explains: 'Some workers literally say to me: "Tell me what to do, and I will do it." (Interview 25).
In light of this still somewhat limited internalisation of self-organisation, another 'restart' is currently ongoing within the organisation. This restart is based on a new model of change, introduced by the coaches. It seeks to achieve a cultural change in the organisation, with self-organisation more enshrined in the attitudes and behaviours of all care professionals. A 'core group' composed of the three coaches as well as the board is drafting the vision for this restart. An important change compared to the last 'revival' is that the board is keen to involve the teams directly in this change. The 'quality nurses' are involved and are seen as 'the bearers of the new culture'. They participate in brainstorms about the new vision and core values of the organisation, and were present at the recent kick-off event. The initial reactions from this group to their involvement is very positive (Interview 25).

The solution

To start with, the effects of the introduction of self-organising teams on the quality of work of nurses and other care professionals vary for the various teams. Some teams experience less difficulties in carrying out these tasks, or have more strongly internalised the concept of self-organisation. These teams are also the ones that feel more heard and seen as a result of this approach. The coach notes that these highly performing teams tend to be teams where people of various levels of educational attainment work together. While teams which experience more difficulties tend to be teams with only lower educated care professionals. Higher educated colleagues tend to have an easier time and are more willing to take up self-organising tasks – and these are also the people who experience the greatest gains in autonomy (Interview 25). Both management and the coach stress that it is not exclusively about educational attainment, even though that is the general trend. Rather, educational attainments tend to be indicative of the things that really matter: personal 'entrepreneurship' or the willingness and openness to change (Interview 24, 25).
Thus, it is crucial that there are sufficient people in each team who are able and willing to take up organisational tasks in order to actually improve the autonomy of care professionals (Interview 23, 24, 25). These tasks can become a burden for some employees and it can be sometimes difficult to combine these organisational functions with the core tasks. For example, if a washing machine breaks down a care worker can no longer delegate it to the manager of facilities and finances. Rather, this worker has to mail management and call the supplier himself, and must file this expenditure in the right program under the right heading – new acquisitions in one program, and repair or maintenance costs through another program. A care worker has to do this while taking care of residents, as well (Interview 23).

The management and the coach understand that these changes are challenging, especially for older care professionals. They are more accustomed to the historically hierarchical relations in residential care and less familiar with personal entrepreneurship. To make matters worse, they are also generally less accustomed to working in digital spaces as compared to their younger colleagues (Interview 24, 25). The 100-150 care workers who actively embrace self-organisation and are happy with it, tend to be young. But, management emphasizes, they are not exclusively young: 'More important is that they are young of mind. That they are open to change.' (Interview 24).
With the new 'restart', the organisation may have to accept that the degree of actual self-organisation varies between teams. It is not only about the various ages or levels of educational attainment presented in a particular team, but sometimes also about the practicalities of the team members' working environment. The organisation works with one care professional for around eight clients. This means that workers at some smaller units may work an entire shift by themselves. In these cases, colleagues are further apart, which makes intense collaboration around self-organisation more difficult (Interview 25).
In closing, the process of continuous innovation around self-organisation has not lowered the quality of service the organisation provides. This is currently very high and has always been very high in the past (Interview 23, 24, 25). In fact, while the older generation of workers tend to have more difficulties in adapting to new situations, they are invaluable for the organisation. They are most experienced and knowledgeable, which is why it is imperative that the organisation finds ways to increase their commitment to self-organisation (Interview 25).

The implementation

One success factor behind the innovations made with self-organisation is that the organisation in this case is small and hence offers an informal, personal working environment. Management and staff know each other personally, and both know the residents and other clients they are working for (Interview 23, 24, 25). This is also useful in picking up unintended consequences of the organisational changes, or picking up grievances amongst staff members. As the coach notes, who has worked at a large organisation in the past: 'There is always someone who listens, and you can raise an issue with management. This helps reduce the unrest which usually accompanies organisational change.' (Interview 25).
Both a blessing and a burden is the fact that workers at this organisation tend to be relatively old and experienced, having worked in this organisation for a long time (Interview 23, 24, 25). The care professional notes that she herself and many of her colleagues have been working at the organisation for two decades or longer. They continue working there because of the informal and collegial atmosphere and the rewarding contact with residents they know well. In addition, as the care professional herself notes, especially the more experienced workers are very dedicated to their jobs. They continue to work in the sector because they care about their clients. For example, when an elderly woman which she cares for trips and falls, she will immediately get on her bike and go to work – even in weekends or on other free days. As she explains: 'I have to be there for her. If this elderly woman, who may have dementia for example, sees a new face, she may get scared.' (Interview 23).
The coach notes that the relatively large experience of staff and their dedication to the clients is what probably has kept the quality of service so high, despite all the organisational changes that have taken place. Unfortunately, experience often goes hand in hand with age – and the median age of care workers at the organisation is 53 (Interview 25). This is older than the average in the sector, the age group from 35 to 55 being the largest age group in the Dutch LTC sector (as reported in chapter one of this report). This relatively high age may pose an

obstacle to self-organisation, because people are less accustomed to social and technological innovations as well as because people may be less open or willing to change (Interview 24, 25). Older workers tend to feel left behind when 'another' round of changes occur, so it is very important for the organisation to actively involve more staff members in the new 'restart' of self-organisation (Interview 24).

The last but definitely not the least obstacle to the implementation of self-organising teams in this organisation are its limited means in terms of finances and, especially, personnel. To start with the financial aspect, as earlier mentioned, the organisation has funds of around 250 to 300 euro's per client. These funds must also be used to finance the move towards self-organisation, including the salary of the coaches. This is a 'major investment' for such a small organisation, but it is very much a necessity if the organisation wants to enhance the autonomy of care professionals (Interview 24).

Yet, the limited available personnel is probably the greatest challenge to self-organising teams this organisation is confronted with (Interview 23, 24, 25). Of course, the whole sector is currently plagued by staff shortages. In addition, this organisation loses quite a few potential new colleagues to the larger competitors in the area – which can offer more comprehensive professional career tracks (Interview 24). Still, an improved implementation of self-organising teams could support current and new care professionals in acquiring and maintaining organisational and entrepreneurial skills (Interview 24, 25).

The main obstacle the staff shortages pose for self-organisation is that the 'extra' managerial tasks given to care professionals are not always compensated with extra time and sometimes have to be performed on days off (interview 23). These are formally compensated with 'plus hours', but these plus hours cannot be given as paid time off since there is simply not enough staff to honour all requests. The organisation management does offer this professional and her colleagues the option to have these hours paid out in money, but that is not always an attractive option because of tax regulations, so: 'everything hinges on having enough staff.' (Interview 23).

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List of interviews in Part II

Case 1: Child centres and the integration of education and care (ECEC)		
Interview number	**Position interviewee**	**Date**
Interview 1	Program director (NGO for Childcentres)	28-6-2022
Interview 2	Director Childcentre	21-7-2022
Interview 3	HR manager childcentre	9-9-2022
Interview 4	Pedagogical worker 1 (Location 1: least integrated)	19-8-2022
Interview 5	Pedagogical worker 2 (Location 1: least integrated)	27-9-2022
Interview 6	Pedagogical worker 3 (Location 2: most integrated)	7-9-2022
Interview 7	Pedagogical worker 4 (Location 2: most integrated)	7-9-2022
Interview 8	Manager (Location 3: most integrated)	16-8-2022
Case 2: Recruiting and retaining pedagogical staff (ECEC)		
Interview number	**Position interviewee**	**Date**
Interview 9	Policy officer (Employer's organisation)	7-6-2022
Interview 10	Director Childcare organisation	14-9-2022
Interview 11	Human resources manager	3-10-2022
Interview 12	Clustermanager (previously pedagogical staff)	5-10-2022
Case 3: Regionalisation in home-based care (LTC)		
Interview number	**Position interviewee**	**Date**
Interview 13	Procurement advisor (RP)	13-11-2021
Interview 14	Relation manager (RP)	17-2-2022
Interview 15	Quality coordinator (RP)	4-7-2022
Interview 16	Senior policy advisor (large municipality)	30-6-2022
Interview 17	Strategic policy advisor (large municipality)	30-6-2022
Interview 18	Contract manager (small municipality)	1-3-2022
Interview 19	Manager 'wmo' (large care organisation)	10-3-2022
Interview 20	Manager home-based care (medium care organisation)	20-7-2022
Interview 21	Director (small commercial care organization)	22-4-2022
Case 4: Self-organising teams in residential care (LTC)		
Interview number	**Position interviewee**	**Date**
Interview 22	Care worker	10-10-2022
Interview 24	Director & Manager Business Operations	28-10-2022
Interview 25	Team coach	10-11-2022