ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

The Netherlands

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Froukje van der Woude, Katrien de Vaan, Marieke Blommesteijn
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European Social Policy Network (ESPN)

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Summary / Highlights

In the Netherlands, professional long-term care (LTC) is divided between three domains: the municipal domain, for which municipalities receive a state grant; the national domain; and the domain of the health insurers, which is funded by health insurance premiums. The Dutch system of LTC has a long history, but the current system was put into effect in 2015 through the implementation of several reforms in LTC and still needs to "settle". It includes the explicit aim of creating greater individual responsibility, because in the old LTC system citizens had become overly dependent on publicly funded services. People in need of care are expected to arrange (and pay for) services that are considered "generally common", and to remain living in their own homes for longer. This implies that (additional) informal care, general public services and services offered by volunteers play a more prominent role than in the former system. Nevertheless, compared to many other Member States, the Netherlands is still a country in which a large part of long-term care is provided by the state.

A third of all adults provide informal care (not just to family members, but also to friends, colleagues and neighbours) but often not on a daily basis. A small proportion provides intensive informal care. Most informal caregivers combine the care with their paid jobs (in the text below, referred to as informal caregivers with employment). Informal care is more often provided by women, and long intensive care is provided by people who do not work. Women can combine work and care because they more often work part time. Also, in the Netherlands the possibility of flexible working hours is relatively high (53% compared to 38% in the EU-28). These factors seem to influence the take-up of short-term and long-term care leave, which is limited. Furthermore, it is mainly highly educated employees, and employees in large organisations and the public sector who use carer's leave.

In addition to short-term and long-term care leave (Employment and Care Act, *Wet arbeid en zorg* – Wazo) and the Flexible Work Act (*Wet Flexibel Werken* – Wfw) there are tax credits and cash benefits (mainly provided by municipalities) that provide support to carers with dependent relatives. Also a personal budget for the person being cared for (*persoonsgebonden budget – PGB*) can be used to finance care provided by caregivers, but there are indications that municipalities try to limit this. There is no information available on the take-up of these financial measures and the impact of giving informal care on the income situation of informal carers. Therefore, it is not possible to assess whether the benefit levels are adequate to protect informal carers from an increased risk of poverty.

In addition to the above-mentioned measures, municipalities support caregivers by providing advice, counselling and respite support. Support is also given by private, not-for-profit organisations, and there are initiatives to enhance the cooperation between these organisations, policy makers and professionals.

Half of the informal caregivers with employment experience a good work-life balance, but nearly a fifth feel overburdened. People with large jobs (i.e. those working for 32 or more hours per week) experience a poorer work-life balance than those with 'smaller' jobs. Work-life balance is difficult to reach by workers with lower education and the self-employed, and might especially affect the employment of female lower-educated workers.

Flexible work schedules, control over working hours and having understanding colleagues and management are important for the perceived work-care balance of informal carers, in addition to the availability of formal arrangements. In cases of a heavy care burden, these are, however, not sufficient to realise a sustainable work-care balance. The current LTC system makes it even more necessary not only to address the work situation of caregivers, but also their care situation.

The data point towards the conclusion that many workers and employers find the necessary flexibility through formal or informal arrangements to enable a reasonable work-life balance. This can be further improved by (more) employers investing in

being explicit about their concern for informal caregivers (including stimulating the take-up of leave and flexible work arrangements) and in being particularly aware of colleagues with heavy care responsibilities. However, more information is needed, especially on the work-life balance of the poorly educated and the self-employed, to determine whether they need additional measures (and if so, which). Even so, the main challenge is to break through the socio-cultural norms and values that form the basis of the unequal division of labour market participation, career opportunities and care tasks and negatively affect the income and care load of women.

1 Description of main features of work-life balance measures for working-age people with dependent relatives

This report focuses on measures in the Netherlands that are aimed at improving the work-life balance of people of working age with dependent relatives. It consists of two sections. This first contains an overall description of the Dutch long-term care regime that forms the context in which people with dependent relatives provide their care. The remainder of section 1 deals with the measures that exist in the Netherlands to support the work-life balance. Section 2 contains an assessment of these measures: both with regard to the take-up and (expected) effect. The section ends with some policy recommendations.

1.1 Overall description of long-term care regime

In the Netherlands, professional long-term care (LTC) is divided between three domains: the municipal domain (Social Support Act (*Wet maatschappelijke ondersteuning* – Wmo) and Youth Act (*Jeugdwet*)), for which municipalities receive a state grant; the national domain (Long-term Care Act (*Wet langdurige zorg – Wlz*)), which has a similar construction as the Exceptional Medical Expenses Act (AWBZ); and the domain of the health insurers (Health Insurance Act (*Zorgverzekeringswet* – Zvw)), which is funded by health insurance premiums. Table 1 shows the main characteristics by domain. The total budget for long-term care was EUR 28.5 million in 2014.

Table 1 Main characteristics by domain

	Municipal domain (Wmo, Jeugdwet)	National domain (Wlz)	Health insurers (Zvw)
Target group	People who are in need of specific assistance in order to be able to remain living in their own homes.	People who need supervision 24/7 (residential care) and/or will always be in need of care.	People who are in need of specific assistance in order to be able to remain living in their own homes.
Provisions	Household services and house adjustments, personal counselling/support incl. support for informal care and sheltered housing, day care, youth care.	24-hour care, youth care.	Personal care, treatment of sensory-handicapped people, palliative care and intensive childcare.
Means-tested	No	No	No
Income-related contributions	Yes	Yes	No

The system as described above was put into effect in 2015 through the implementation of several reforms in LTC, and still needs to "settle"; however, the Dutch system of LTC has a long history: the precursor of the Wmo and Wlz goes back to 1968. The AWBZ was a national and largely contribution-based scheme which paid for the costs of personal and nursing care, counselling, medical treatment and accommodation. Between 1968 and the turn of the century, a steady increase can be observed in care provisions that were covered by the AWBZ. In response to the rising costs this induced, the last 15 years have seen a development to limit the coverage by the AWBZ to those who are in need of permanent care and/or supervision, in residential homes or close to home, and to those who are most vulnerable: elderly people in need of nursing/care, disabled people and people with (severe) mental disorders (SCP 2014). Important with regard to the topic of this thematic report is the explicit aim of creating more individual responsibility, because in the old LTC system citizens had become overly dependent on publicly funded services. People in need of

care are expected to arrange (and pay for) services that are considered “generally common” and to remain living in their own homes for longer. The care they need is provided by a combination of formal care (Wmo, Jeugdwet, Zvw), informal care by social networks (family, friends, neighbours and other close relatives), general public services, such as meal services or community centres, and services offered by volunteers. Residential care is reserved for those who need 24/7 supervision permanently. However, compared to many other Member States, the Netherlands is still a country in which a large part of long-term care is provided by the state. OECD data state that of the EU-28 countries, the Netherlands had the third-highest public expenditure on long-term care as a percentage (3.7%) of GDP in 2010 and 2011 (SPC and EC 2014).

1.2 Description of carers’ leaves

Short-term and long-term care leave

In the Netherlands, carer’s leave is organised under the Employment and Care Act (Wazo). The act was expanded as of July 2015, and since then gives carers the right to take leave to care not just for a sick partner, child or parent, but also for siblings, grandparents, grandchildren, housemates or acquaintances. Before July 2015, it was only allowed to take leave if the illness of the person cared for was life-threatening. The act has been changed to enable people to provide necessary long-term care for handicapped or sick people as well.[1]

The Wazo act provides for short-term care leave, emergency leave (not taken into account in this report) and long-term care leave.

- The annual amount of **short-term care leave** allowed is double the number of hours worked per week. It can be taken in several spells over the course of the year, so long as it does not exceed this maximum. During this leave, the worker continues to receive 70% of the wages. The percentage may be higher if there is a collective agreement or other regulations made by employers.
- **Long-term care leave** gives people the right to care on a more substantial basis, when required. If there is an immediate need for care, it is possible first to take short-term leave and then switch to long-term leave later. The maximum duration of long-term care leave is six times the weekly working hours per year.[2] Long-term care leave is unpaid, unless there is a collective agreement or other regulation in which employers have made their own decisions about payment. These agreements carry more weight than the national agreements.[3] The number of holiday hours that an employee accrues depends on the weekly hours worked. This accrual continues during long-term care leave, so in addition to care leave an employee can take holidays. The employer is not allowed to subtract these days from the leave.[4]

The self-employed do not have access to short-term or long-term care leave (Yerkes and den Dulk 2015).

[1] https://www.rijksoverheid.nl/onderwerpen/zorgverlof/nieuws/2013/12/12/recht-op-zorgverlof-ook-voor-vrienden-en-bekenden.

[2] https://www.rijksoverheid.nl/onderwerpen/zorgverlof/vraag-en-antwoord/duur-zorgverlof.

[3] https://www.rijksoverheid.nl/onderwerpen/zorgverlof/vraag-en-antwoord/zorgverlof-en-salaris.

[4] https://www.rijksoverheid.nl/onderwerpen/zorgverlof/vraag-en-antwoord/zorgverlof-aanvragen.

Eligibility

An employer is not allowed to judge the need to give care or the type of care. However, he is allowed to ask for information in order to see whether the application for leave is well founded, such as a doctor's statement on the sick/disabled relative. The existing regulations do not define in further detail when care is considered to be "necessarily warranted".

The employer is not allowed to refuse an application for long-term care leave, unless the economic viability of the business or organisation would be seriously threatened. The employer has to decide whether the leave will or will not be granted at least one week before the requested date of leave. If employer and employee cannot reach an agreement, the employee can seek help at human resources, a labour union, or ask for legal assistance.

Once the carer's long-term leave has started, an employer cannot discontinue it. Long-term care leave can be taken on a part-time or full-time basis.

If an employee becomes sick or disabled during full-time care leave, he/she is not insured for sickness, disability or unemployment benefits. However, employees do have the opportunity to enter into a voluntary insurance contract with the Employee Insurance Agency (*Uitvoeringsinstituut Werknemersverzekeringen* – UWV) for sickness during leave.[5]

If a person falls ill during full-time leave, he is not insured under the Continued Payment of Salary During Sickness Act (*Wet verlenging loondoorbetalingsverplichting bij ziekte* – VLZ*)* and therefore receives no payment or salary. In case of sickness during part-time leave, part of the salary is paid for the hours that the employee otherwise would have worked (70% of last earned wages). The employee can negotiate with the employer to discontinue the leave during his illness, in order also to receive salary for the leave hours.[6]

Flexibility

In order to improve adjustments in working hours the Flexible Work Act (Wfw) was implemented in 2016.[7] This act is a transformation of the former Working Hours Adjustment Act (*Wet aanpassing arbeidsduur* – Waa). The Waa only stipulated the right to request adjusted working hours (fewer or more hours a week). Under the Wfw employees can also request an adjusted workplace or adjusted working time (the hours or days during which he or she will work). As with the Wazo, employers can only refuse such a request if the economic viability of the company is seriously threatened.[8] The intention of the transformation is to make it easier for employees to combine their work with care tasks.[9]

1.3 Description of carers' cash benefits

Carer allowance

There are in the Netherlands no care allowances that compensate informal carers for their work. The only exception is the personal budget scheme (*persoonsgebonden budget* – PGB) that exists under all four laws that govern LTC. This budget can be used to finance care by both professional and informal caregivers. In order to obtain a personal budget, clients have to explain why the available in-kind care is not suitable for them. If they want to use their personal budget to pay for an informal carer, they have to comply with rules regarding forms of care and payment and lay down

[5] https://www.rijksoverheid.nl/onderwerpen/verlofregelingen/vraag-en-antwoord/welke-gevolgen-heeft-onbetaald-verlof-voor-mijn-vakantiedagen-uitkering-toeslagen-of-pensioen

[6] http://www.arbeidsrechter.nl/aanvraag-recht-op-langdurend-zorgverlof-werknemer

[7] For companies with 10 or more employees.

[8] http://wetten.overheid.nl/BWBR0011173/geldigheidsdatum_26-01-2016

[9] https://vng.nl/onderwerpenindex/arbeidsvoorwaarden-en-personeelsbeleid/arbeidsvoorwaarden/nieuws/modernisering-regels-verlof-en-arbeidstijden

arrangements in a formal agreement. Rules regarding personal budget schemes under the Wmo and Jeugdwet may differ from one municipality to another. This has led to a lack of clarity about the criteria that has yet to be addressed. There are indications that some municipalities make it almost impossible to use the personal budget scheme to pay informal carers.[10] Personal budget payments differ from wages, in that they do not cover social or pension contributions. However, PGB payment is taxable income. Also, this payment can be included in the sum to calculate the amount and duration of unemployment benefits.[11]

Cash benefits to pay for care services

Clients and their informal carers can obtain several cash benefits to pay for care services. Municipal budgets are not earmarked:

- Municipalities are expected to financially support inhabitants with high healthcare costs, but they are not obliged by law to do this. These allowances are not aimed at improving the work-life balance (financial situation) of informal caregivers.
- Some municipalities pay for travel costs of informal carers on minimum income.[12]
- Parents of severely handicapped children can receive extra child benefits paid by the Tax Authorities (*Belastingdienst*).[13]
- Unemployed people receiving unemployment benefits or social assistance can be granted a temporary exemption (for a maximum of six months) from job-seeking activities (if the person concerned does have labour market opportunities), if they are caring for a family member or friend. For people who receive benefits, the temporary exemption from the obligation to accept a job logically does imply that they are temporarily not available for the labour market. Additional conditionality rules are set to prevent the care for others resulting in a structural withdrawal from the labour market. The exemption includes the obligation, most specifically for those receiving unemployment benefits, to find alternative solutions for the care that is provided by them.[14]

Tax credits, tax incentives or reductions

Informal caregivers do have rights to some tax benefits, but these are not especially intended to improve the work-life balance. The benefits mainly apply to minimum-income households.

Informal carers with high expenses that are related to the care they provide (e.g. travel costs, costs for hiring domestic help in case of sickness of the caregiver, for adjustments to the house or car, etc.[15]), can deduct these from their income tax. Also the costs that family members incur because of their dependency on the carer[16] can be deducted from the income tax. Only expenses that are higher than a certain threshold can be deducted (Hoek 2015).

The costs of temporary (overnight) stays at home (or a holiday address) by a severely disabled child, sibling or person for whom the carer is the mentor or the trustee, and who normally lives in a healthcare facility, can also be deducted from income tax, if

[10] Tweede Kamer der Staten-Generaal, Vergaderjaar 2015–2016, Aanhangsel 827.

[11] http://www.uwv.nl/particulieren/werkloos/ik-word-werkloos/detail/achtergrondinformatie-over-de-ww/uitleg-over-de-duur-van-een-ww-uitkering/totale-arbeidsverleden

[12] https://www.mezzo.nl/pagina/voor-mantelzorgers/thema-s/geldzaken/vergoedingen

[13] https://www.rijksoverheid.nl/onderwerpen/kinderbijslag/inhoud/recht-op-kinderbijslag

[14] http://www.uwv.nl/particulieren/werkloos/uw-rechten-en-plichten/detail/plichten-met-ww-uitkering/solliciteer-actief-naar-passend-werk/wanneer-hoef-ik-niet-te-solliciteren and Participation Act (*Participatiewet*) http://wetten.overheid.nl/BWBR0015703/2016-01-01.

[15] http://www.stemvandemantelzorger.nl/belastingaftrekzorgkosten.html

[16] Without the care of the informal carer they would have depended on professional care.

the person being cared for is over 20. There is no threshold with regard to the deduction of these costs.[17]

Taking long-term care leave means that income may decrease. If income drops below a certain minimum income threshold, extra compensation – e.g. for childcare, health insurance, housing allowance – may apply.[18] In this case, carers are not supported by the Wazo, but by the regular social safety net.

1.4 Description of carers' benefits in kind

Municipalities are mainly responsible for the support for informal caregivers. The budget for this task is EUR 100 million per year.[19] Municipalities offer many forms of support from this budget. Types of support may differ from one municipality to another; unfortunately, there is no overview of what municipalities supply in general, or of the main differences between municipalities. Types of support may include, for example:

- Information and advice on benefits to carers and assessment of carers' needs (most municipalities have a support function for informal caregivers to help them with any questions regarding care and support);
- Emotional support/counselling by both professionals and volunteers, and through opportunities to meet other informal carers;
- Courses on aspects of care, on diseases and on network formation;
- Practical help for the person being cared for (e.g. domestic help and meal services) and for the carer (administrative help and mediation in employment issues);
- Material help for the person being cared for, such as home adjustments, or a parking permit for the carer;
- Respite support, such as day care, short-term residential care, crisis care or holiday care;
- An active role in stimulating professional caregivers to cooperate with informal carers (Radar 2015).

Most health insurers have included a certain number of days' respite support in the supplementary insurance packages (not the basic health insurance[20]).[21] In other cases, respite support is paid for out of the Wlz, if the person being cared for receives care under the LTC Act (Wlz), or out of the Wmo/Jeugdwet, if he or she receives care under these laws. There are no regulations as to the amount of respite support that carers should be able to rely on. With these acts, the national government wants to support municipalities in paying attention to the well-being of informal carers.

In addition to these acts, there are multiple organisations which have been established especially to support informal carers and volunteers in municipalities. Together with the national government, representatives of these support organisations, professional and interest organisations (e.g. (municipal) care organisations, insurance companies and client organisations) have formulated a "future agenda for informal care and support" (VWS and Expertisecentrum Mantelzorg 2014). This agenda stresses the cooperation between government, professional care, informal care and several supporting organisations, in order to make it easier to give informal care.

[17] http://www.meerkosten.nl/index.php?option=com_content&view=article&id=123&Itemid=147

[18] http://www.arbeidsrechter.nl/aanvraag-recht-op-langdurend-zorgverlof-werknemer

[19] https://www.rijksoverheid.nl/onderwerpen/mantelzorg/inhoud/veranderingen-voor-mantelzorgers-en-zorgvrijwilligers.

[20] Since 2006, all residents have been required to purchase a basic health plan covering, among other things, family medicine, maternity care, pharmaceuticals and hospital care. Supplementary health insurance packages are optional and cover services which are not covered by the basic health insurance scheme, for example, physiotherapy and dental care for adults.

[21] https://www.mezzo.nl/pagina/voor-mantelzorgers/thema-s/geldzaken/vergoedingen

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

A recent study of informal care in the Netherlands (SCP 2015) shows that:

- 33% (4.35 million people) of all adults give informal care (not just to family, but also to friends, colleagues and neighbours); 14% (c. 610,000 people) of these give intensive informal care (more than eight hours per week and for longer than three months); the large majority of informal carers (73%, c. 318,000 people) give long-term, but less-intensive informal care.
- Women give more informal care than men. While men provide care to their partners more often than do women (54% vs 46%), women more often provide care to a parent (58% vs 42%) and to a child (73% vs 27%).
- The fact that women give more informal care than men is also shown in the results of the European Quality of Life Survey (2012):[22] 25.2% of men are involved in caring for elderly or disabled relatives, compared to 32.1% of women. Dutch people provide care to their relatives more often than in the EU on average: in the EU, 26.7% of women and 22% of men are involved in providing informal care to elderly or disabled relatives.
- The survey shows that the intensity of care that is provided differs between women and men: 3.6% of women and 2.3% of men provide care to elderly or disabled relatives **each day**. People in the Netherlands are less often involved in giving informal care on a daily basis than the EU average: 7.3% of all women in the EU and 4.1% of all men in the EU are involved in this kind of care.
- People with part-time jobs give more informal care than others. Long-term intensive informal care is more often given by people without employment.
- Most informal caregivers combine the care they provide with their paid jobs (84%) (in the text below referred to as informal caregivers with employment); 72% of male informal caregivers have a job that takes up (at least) 32 hours, compared to 28% of female informal caregivers.
- Regarding the flexibility of carers' jobs, the European Working Conditions Survey (2015)[23] shows that 55.4% of Dutch workers are able to vary their start and finish times (compared to an average of 39.7% in the EU-28). This does not differ much between men and women. But it does differ between poorly and highly educated people (53.9% and 70.7%, respectively, are able to vary their working times).

2.1.1 Carers' leaves

Coverage

There is a legal obligation for employers to grant care leave, as described in section 1.2. In that sense, all employees can take care leave. Moreover, there are ways to make adjustments to collective agreements in favour of employees. Short-term care leave arrangements exist in 69 of the 100 largest collective agreements in the Netherlands; long-term care leave arrangements in 43 of those agreements. With regard to long-term care leave, there are large differences in payment during take-up. Self-employed persons do not have access to short-term or long-term care leave (Yerkes and den Dulk 2015).

[22] See: Statistical Annex in Synthesis report on Work-life balance measures for persons of working age with dependent relatives.

[23] See: Statistical Annex in Synthesis report on Work-life balance measures for persons of working age with dependent relatives, revised version.

Take-up

Of all informal caregivers (also supplying care to people outside the family circle) 5% take unpaid leave and 7% take paid leave. It is not known whether this concerns short-term or long-term care leave (SCP 2015). When we take an organisational perspective, we see that short-term leave is being taken in about 50% of all organisations, and long-term care leave in 10%. Both short-term and long-term care leave are more often requested in organisations with highly educated employees, large organisations and the public sector; long-term care leave is also more often applied for in the care sector (Lippényi and van der Lippe 2015).

As the two tables below show, people take different types of leave in order to provide care to long-term and short-term sick people. Only 8,000 employees (15–65 years old with a job for 12 hours or more per week) took long-term care leave in 2013; most people took short-term care leave, holidays or compensation hours.

The sick persons mentioned in Tables 2.1–2.6 are sick family members. Their (demographic) characteristics are not further specified by Statistics Netherlands (*Centraal Bureau voor de Statistiek, CBS*), but it gives examples such as a child, partner or parent as possible "sick person".

Table 2.1 Carers for long-term sick people, taking leave (2013)

x1000	Total	Men	Women
Number of employees giving care to a long-term sick person	443	198	245
Number of employees taking leave	74	33	41
Type of leave			
Holidays or compensation hours	23	14	9
Emergency leave	4	2	2
Special leave	11	6	6
Short-term leave	26	9	16
Long-term leave	8	3	5
Unpaid leave[24]	2		2
Other types of leave	4	2	2

Source: http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=71516NED&D1=0-2,5-7&D2=a&D3=l&HDR=G1,G2&STB=T&VW=T

[24] Meaning unpaid leave not related to formal short- and long-term care leave.

Table 2.2 Carers for short-term sick people, taking leave (2013)

x1000	Total	Men	Women
Number of employees giving care to a short-term sick person	431	200	232
Number of employees taking leave	151	76	75
Type of leave			
Holidays or compensation hours	65	34	31
Emergency leave	11	5	6
Special leave	15	9	7
Short-term leave	40	18	22
Unpaid leave	6	4	2
Other types of leave	19	9	10

Source: http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=71516NED&D1=78-79,83-84&D2=a&D3=l&HDR=G1,G2&STB=T&VW=T

The CBS dataset distinguishes between people who gave care to someone in need of care but did not take leave, and people who had a family member/friend in need of care but did not provide care to this person (and did not take leave either). The four tables below show the numbers and the reasons why people did not take leave or did not provide care.

Table 2.3 Carers for long-term sick person, not taking leave (2013)

x1000	Total	Men	Women
Total number of employees who did not take leave, even though they felt they needed it	76	31	45
Financially unviable	11	5	6
Work would not allow it	29	11	17
Not familiar with regulations	6	2	4
Too little leave	5	2	3
Other reasons for not taking leave	25	10	14

Source: http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=71516NED&D1=78-79,83-84&D2=a&D3=l&HDR=G1,G2&STB=T&VW=T

Table 2.4 Carers for short-term sick person, not taking leave (2013)

x1000	Total	Men	Women
Number of employees who did not take leave, even though they felt they needed it	49	20	29
Financially unviable	5	2	2
Work would not allow it	21	9	12
Not familiar with regulations	3	2	
Too little leave	3		3
Other reasons for not taking leave	16	6	10
Number of employees who did not take leave, and did not feel they needed it	226	101	125
Use of leave and need to take leave unknown	6	3	3

Source: http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=71516NED&D1=78-79,83-84&D2=a&D3=l&HDR=G1,G2&STB=T&VW=T

Table 2.5 Reasons for not caring for long-term sick person (2013)

x1000	Total	Men	Women
Number of employees who did not give care to a long-term sick person	154	109	46
Number of employees who wanted to, but did not give care	73	51	22
Too burdensome	3		
Work would not allow it	29	23	6
Care given by somebody else	20	12	8
Other reason not to give care	21	13	8
Total number of people who did not want to give care	81	58	23

Source: http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=71516NED&D1=62-72&D2=a&D3=l&HDR=G1,G2&STB=T&VW=T

Table 2.6 Reasons for not caring for short-term sick person (2013)

x1000	Total	Men	Women
Number of employees who did not provide care to a short-term sick person	208	120	88
Number of employees who wanted to, but did not give care	65	44	21
Work would not allow it	30	24	6
Care provided by somebody else	18	11	7
Other reason not to provide care	15	8	7
Number of people who did not want to give care	143	76	67

Source: http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=71516NED&D1=114-124&D2=a&D3=l&HDR=G1,G2&STB=T&VW=T

These last four tables show that many carers who do not take leave even though they feel they need it refrain from taking leave because their work does not allow it. Conversely, work is an important reason for refraining from providing care to dependent, sick people (but also the fact that care is already given by others). The reason "why work would not allow it" has not been further investigated; therefore it remains unknown if the possibility to take leave was even discussed, if a request was refused, or because it was financially unviable. Moreover, the background characteristics of the respondents are not known, so we do not know if differences in types of jobs or education level are of any significance.

The Netherlands has a long tradition of supporting part-time work. During the 1980s, part-time work became a central policy in order to promote women's employment. Reforms also created a right to work part time and adjusted eligibility criteria so that part-time workers have similar rights as full-time workers (Hemerijck et al. 2013). In combination with a history of mainly unpaid leave (especially for long-term (child) care), it is assumed that people organise their working life around care tasks (Hemerijck et al. 2013). In practice, the combination of full-time and part-time work is most common among working couples with young children, also known as the *anderhalfverdienmodel.*

Effects on employment and well-being

In view of the limited take-up of carers' leaves, the effect of these leaves is expected to be small. Employees themselves more often seem to look for opportunities to balance work and care in flexible work arrangements, such as part-time work and the autonomy to decide on their own working schedule, and feel supported by understanding managers and colleagues (SCP 2015).

The well-being of caregivers is, among other things, expressed by the way they perceive the burden of care. Nearly 10% of all caregivers feel overburdened by their caring responsibility (SCP 2015). Another study shows that this percentage is higher among informal caregivers with employment: 19% (Plaisier et al. 2014). The study of SCP shows that even when the level of intensity of care is the same, workers perceive a higher burden of care than non-workers. People who work for 32 or more hours per week experience a poorer work-life balance. The same goes for people who give intensive informal care and people who have a rigid work schedule (SCP 2015). Even so, half of those informal caregivers with employment in this study experience a good balance in combining work and informal care (Plaisier et al. 2014).

2.1.2 Carers' cash benefits

The eligibility criteria for carers' cash benefits have, as far as possible, been described in section 1 (the limitation is due to decentralisation of part of the long-term care to municipalities). Little is known about the take-up of these benefits. Take-up of the personal budget scheme in general is measured, but not whether the budget is spent on formal or informal care. Therefore, nothing is known of the effect of this specific form of cash benefit on employment. However, in view of the fact that the use of the personal budget scheme seems to have been severely limited by municipalities since 1 January 2015, little effect is expected.

The same probably applies to the use of tax benefits. These do not add up to such amounts that effects on employment can be expected.

2.1.3 Carers' benefits in kind

There are no limits on the coverage of the benefits in kind that were described in section 1 – except perhaps limits that apply to income-related contributions. Of take-up almost nothing is known. The SCP reports that around 25% of informal caregivers use respite care, mostly day care; however these figures date from before the decentralisation to municipalities.

A possible effect of these in-kind benefits is that they relieve the emotional burden on informal caregivers, thereby obviating the need for sick leave (or even job terminations). However, not much is known about the effects.

2.2 Assessment of overall package of measures and interactions between measures

Carers' leaves and benefits in the Netherlands coexist with flexible work arrangements, such as the right to work part time, and to adjust one's work schedule or workplace. The effects of measures such as care leave and benefits for carers should be regarded in tandem with these other opportunities to combine work and care. Two questions seem to be especially important: do informal caregivers feel supported in their combination of work and care by their employers and co-workers? And do they feel able to combine work and care, both financially and emotionally?

We have seen that little use is made of formal care leave, either short-term or long-term. This might be due to a lack of knowledge, the fact that long-term care leave is mostly unpaid and the fact that take-up used to be restricted to caring for a child, partner or parent. However, it may also be due to the fact that many informal caregivers do not perceive an imbalance between care and work; this could be linked to the opportunities that exist to work part time, at home or to influence one's own work schedule. This does not explain why Tables 2.3 and 2.4 show so many employees who could not take care leave because their work would not allow it or because it was financially unviable. The story behind the figures is unknown, and so we can only second-guess what could be the explanations for the limited use that is made of formal care leave.

The impression that caregivers do not perceive an imbalance between care and work is not fully supported by what we do know about access and take-up. For instance, Yerkes and den Dulk (2015) show that some groups have less access than others to flexible work arrangements (such as those mentioned above): the highly educated have greater access than those with a lower education; and these arrangements enable women, more often than men, to combine work with care. We would expect, therefore, to see men in jobs with more hours per week and lower-educated workers struggling more with the work-life balance than higher-educated female workers either with no jobs or with jobs that involve fewer hours per week; and indeed, the SCP finds that people who work for 32 hours or more a week do experience a worse work-life balance (the same is true of people who give intensive informal care and people who have a rigid work schedule; SCP 2015). Lippényi and van der Lippe (2015) find that work autonomy and part-time work are alternatives to taking up short-term care leave, since they also leave employees the flexibility to arrange their work schedule around care tasks.

Yerkes and den Dulk (2015) attribute the inequality in access to flexible work arrangements to a combination of socio-cultural factors and the availability of measures. In the Netherlands, socio-cultural norms still prefer women as carers (rather than men). As a result, women work fewer hours in formal employment than do men. This also becomes apparent in, for instance, the take-up of childcare facilities. Childcare facilities are considered acceptable and are used, but rarely full time. Among the lower educated, more people (over a third of both men and women) feel that women should be prepared to work less, for the sake of the family; among the highly educated, this percentage is around 20%. Part-time work is the main strategy for women to combine work and care. There is a risk inherent in this strategy: part-time work means less financial independence, and the strategy of using part-time work to combine work and care tasks may contribute to the continuing unequal situation of women and men in terms of both the labour market and financial independence. Also, in view of the fact that, for quite a large number of workers, work is a reason **not** to give care or **not** to take the leave to which they are entitled, and given that in particular highly educated workers take leave and the self-employed do not have the right to short-term or long-term care leave, it would appear that achievement of a work-life balance is hardest for workers with lower education and for the self-employed (the latter group is growing quickly), and might especially affect the employment of female lower-educated workers.

Research in the Netherlands shows that flexible work schedules, control over working hours and having understanding colleagues and management are important for the perceived work-care balance of informal carers, in addition to the availability of formal arrangements. In cases of a heavy care burden (approximately 600,000 people care for more than eight hours/week and for longer than three months – SCP 2015), these arrangements are, however, not sufficient to realise a sustainable work-care balance; in those cases, the care situation needs to be addressed as well (Plaisier et al. 2014). This last point is important to stress, since in relation to the long-term care reforms the government is explicitly stressing the need to decrease the amount of formal support and assistance.

The Dutch national association for informal carers and voluntary care (Mezzo, which has 350 associated organisations) has three "prongs" for informal carers, in order to contribute to the necessary decrease in formal care: customised support should be available to them (e.g. respite care); there must be collaboration between formal and informal care (by providing a timely mix, instead of waiting with formal care until the informal carer already experiences an imbalance); and they need to have support to combine work with care. In order to achieve this last prong, Mezzo is pleading for an informal carer-friendly staff policy to be inserted into all collective agreements. Employers, social partners and the government must support this.[25]

The work-life balance measures help people of working age who are caring for dependent relatives. The benefits (paid leave, cash benefits, tax credits) that are available can partly compensate for the costs of caring for a dependent relative (loss of income, travel costs, etc.). There is no information available on the impact of giving informal care on the income situation of informal carers. Without this information, it is not possible to assess whether the benefit levels are adequate to prevent informal carers from suffering an increased risk of poverty.

There is also little detailed information on the risk of poverty of those who receive informal care. Figures concerning the life expectancy of people in low-income households[26] (CBS 2015) and the overrepresentation of people on social benefits at risk of poverty (SCP/CBS 2014) suggest that those who need care have an increased risk of poverty. To what extent they receive informal care is unknown.

2.3 Policy recommendations

Based on the data in this report, it is not possible to state with certainty whether there is a problem regarding the work-life balance in the Netherlands. Short-term (paid) and long-term (in most cases unpaid) care leave is available to all employees (though not the self-employed), but take-up is very limited. There are several cash and in-kind benefits for caregivers, but their effect on the work-life balance is probably limited, as they only partly compensate carers for their care work. Part-time work and flexibility over working hours and the workplace enable people to combine work with care tasks. Combining work and care is not perceived as a problem by the carers themselves, though informal caregivers with employment more often experience an imbalance. The data point towards the conclusion that many workers and employers find the necessary flexibility through formal or informal arrangements to enable a reasonable work-life balance. This can be further improved by (more) employers investing in being explicit about their concern for informal caregivers (including stimulating the take-up of leave and flexible work arrangements) and in being particularly aware of colleagues with heavy care responsibilities. Although this approach may involve costs, employers also benefit from a better work-life balance for their employees, because overburdened caregivers are at risk of absenteeism, and may consider reducing their working hours or quitting their jobs.

[25] Source: https://www.mezzo.nl/pagina/over-mezzo/mezzo/waar-staat-mezzo-voor

[26] The (healthy) life expectancy of persons in low-income households is lower than that of persons in high-income households (CBS 2015).

However, a closer look reveals several concerns. The take-up of formal care leave is very limited, and it would be interesting to know more about why this is so. Possible answers are that it is not needed or that the possibilities of flexible working hours/workplace and part-time work offer enough opportunities to combine work and care duties. But reasons may also lie in unattractiveness, because of the fact that long-term care leave is unpaid. Or it may be that take-up of formal care leave is frowned upon in a culture in which workers are expected to use flexible working hours/places and part-time options to combine work and care tasks, without it being at a cost to employers. Or, another possibility, the formal arrangements are simply not very well known. Because some of these potential reasons are highly undesirable, it is necessary to learn more about the reasons for the limited take-up, so that necessary measures can be developed.

It seems that two groups in particular have less access to formal care arrangements: those with lower education and the self-employed (these groups partly overlap). The opportunities offered by part-time work and flexible working hours/workplace are most likely less available to workers with lower education and low wages (because these jobs are more often bound to specific times and places, and part-time work means even lower income) than to better-educated workers. It is therefore possible that lower-educated, poorer-paid and self-employed workers (who have no access to leave arrangements) experience a worse work-life balance than other groups. If further research shows this to be the case, policy makers should consider possible additional measures that benefit especially these groups.

Another concern is the unequal division of labour market participation and care tasks. In general, men work full time while women most often work part time. With regard to care for children, we know that the preference to (partly) take care of children ourselves is still strong. As a consequence, women choose to work part time.[27] The question is whether this is also applicable to caring for dependent others. Anyhow, in practice women pay the price, not just because they are the main care providers, but also because as a result of working part time, fewer of them are economically independent than are men. Unequal division of tasks has long-term consequences, because working part time also negatively affects women's income after their retirement age (second pillar: occupational pension scheme). However, the state pension (first pillar) is not related to the work history of (wo)men.

In the Netherlands the incidence of part-time work is to a large degree based on personal preferences and is deeply rooted in Dutch society, including the notion that career opportunities are best for those in full-time employment who are available full time. Time and career demands are primarily fixed on the ideal of the full-time male employee, with a partner who works part time (*anderhalfverdienmodel*). Yerkes and den Dulk (2015) state that existing leave arrangements seem to confirm the current socio-cultural norms and values, instead of challenging these. Ideas about the ideal employee will have to change for flexible work arrangements to be a success and for take-up of leave arrangements not to endanger career opportunities. Alternatives for the *anderhalfverdienmodel* are needed, so that working carers can feel better supported in combining work and care; this would relieve an important part of the burden of caring (SCP 2015) and would have a positive effect on the well-being and motivation of workers (Schakel et al. 2013). Yerkes and den Dulk (2015) look for solutions in the extension of care arrangements, in terms of both length and payment, but also imply that more thorough policy changes are necessary to offer workers a better work-life balance, such as policies that respond better to diversity in society.

[27] The combination of full-time and part-time work is most common among working couples with young children, also known as the *anderhalfverdienmodel.*

Breaking through the cultural barriers takes more than the introduction of new instruments. In the meantime, the continuation of (municipal) support for caregivers is needed. We underline the current efforts that are made by municipalities and support organisations for caregivers to help them cope better with their care tasks and prevent overburdening.

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