Eurofound

More and better jobs in home-care services

The Netherlands

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Introduction

This country report gives an overview of the labour market policy in community-based care for adults with disabilities in the Netherlands. The main topics discussed are the context in which community care labour market instruments are implemented, the funding structure, the strategies used to recruit new employees and retain current workers in the sector and the resulting impacts and outcomes. Three case studies were carried out into initiatives in the field of labour market policies in community-based care to support adults with disabilities: Neighbourhood Training Company, Visible Link and Netherlands Neighbourhood Care. Annex 1 to this report contains summaries of the three case studies and analyses the main outcomes and success factors.

1 Policy background

Overview of the care sector in the Netherlands

Community care workers in the Netherlands work mainly in home-care services, community-based mental care, community-based care for people with disabilities and community-based social care. Companies operating in the cleaning branch are also active in these fields.

In the Netherlands, the share of community-based care in total care is already relatively high. The Care Assessment Centre (Centrum Indicatiestelling Zorg, CIZ) judges whether or not people are entitled to long-term healthcare on the basis of objective criteria, which come from guidelines from the Dutch Ministry of Health, Welfare and Sports (Ministerie van VWS). Currently, 38% of all people who are eligible for long-term healthcare are eligible for community-based care (extramurale zorg). This share is smaller for adults below the pension age than for the elderly. For instance, with regard to somatic disorders, the share of community-based care for people aged 0–64 years, 65–74 years and 75 years and older is 28%, 34% and 56% respectively.

At present, the Dutch municipalities are responsible for contracting out some home-care services, namely household work. There are also plans to give the municipalities responsibility for the accompaniment and guidance of patients who live at home.

Reasons for developing and maintaining community-based care services

The costs of the Dutch care system are high and continue to grow. Cost reduction policies are increasing the level of community care (extramuralisering) and place responsibility at the community level (zorg in de buurt). Another goal for community care is to increase patients' ability to live and do things independently for as long as possible (zelfredzaamheid).

Type of community care services available

In the Netherlands, there are various forms and types of community-based care services.

Residential forms:

- assisted living residential areas (woonservicegebieden), mainly but not exclusively aimed at elderly people;
- assisted living complexes (woonzorgcomplexen), mainly but not exclusively aimed at elderly people;
- small-scale residences (kleinschalig wonen), such as the ADL cluster or Fokus-residences for people with disabilities;
- assisted living residences (beschermd wonen);
- services in people's own homes;
- care homes (zorghotels).

Organisational forms:

- services by regular care institutions;
- services by self-employed care workers;
- care cooperatives (zorgcoöperaties) – a care cooperative is an association with members that supplies services and care to these members; the aim is to keep services and care in one's own control.

Types of services:

- home-care services (thuiszorg);
- district nursing services (wijkverpleegkunde), by the Buurtzorg organisation, for example;
- ambulatory services (ambulante hulpverlening), in welfare care, care of alcoholics and drug addicts, and so on;
- buddy services, such as those for HIV or AIDS patients, mainly by volunteers;
- multidisciplinary district teams (wijkteams), consisting of family doctors, district nurses, district coordinators of housing corporations and welfare workers;
- telecare (zorg op afstand);
- online support and treatment, mainly in mental care.

Labour market situation

At the moment, there are relatively few shortages in community-based healthcare (mainly at level 3 of intermediate vocational education[1] and for some specific professions), but in the coming years, these shortages will probably increase and also appear at higher qualification levels (Panteia and SEOR, 2012). Due to the Dutch government's cost reduction policies, there is and will be a surplus of labour in social care.

The qualifications, skills or competences that employers demand from community care workers are increasing, mainly as a result of the expanding coordination role they have to play.

The labour market for community care workers is fairly transparent. Work in the sector is not unpopular, but there is room for improvement. For instance, the image of work in home-care services (associated with autonomy, freedom and variation) has always been more positive than that of work in nursing homes and homes for the elderly (associated with teamwork, high work pressure, and physically and mentally heavy work) (Maximum, 2009). However, recently in home-care services there has been a shift from higher-qualified care personnel to lower-qualified cleaning personnel (partly due to contracting out by municipalities). This negatively influences the image of work in the branch.

PESTLE analysis

The research used the 'PESTLE' model to identify the external factors influencing the development of the labour market. The six dimensions in the PESTLE model are the *political*, *economic*, *social*, *technological*, *legal* and *environmental* dimensions. The PESTLE approach was originally a business-study model used to describe a framework of relevant factors at the macro level, used mainly for analysing the business environment of organisations. It is a means of measuring strengths and weaknesses against external factors and can help organisations develop strategies. In the same way, a PESTLE analysis can also be used for a contextual analysis of sectoral labour markets.

These six dimensions can greatly influence the sectoral labour market, although some are obviously more important than others. In the context of the research into the care sector, particular consideration must be given to the political and economic dimensions, as these have a direct effect on the possibility of creating attractive and useful jobs in the community-based care sector. The financial dimension is of special importance in this context, since this is not a commercial sector, but one generally financed with public money.

Since the situation in the different countries included in the research is different, the labour market discrepancy model connected to the PESTLE factors can identify where the issues lie in each country. The model provides, in a sense, a common language that describes the challenges

[1] Intermediate vocational education roughly corresponds with ISCED level 4 (post-secondary non-tertiary education). In the Netherlands, four qualification levels are distinguished in intermediate vocational education.

faced by the different actors. As previous research has already shown that there is a general shortage of labour in the sector, and in some cases a shortage of jobs, it is to be expected that there are clear discrepancies. The model can swiftly record whether these are qualitative or quantitative, due to a lack of influx into the sector or too great an outflow than can be compensated for, or whether they are triggered by developments in one of the PESTLE dimensions. At the same time, the model offers a structured means of comparison.

Political and legal factors

The new cabinet (Rutte II) has continued the policy of increasing the level of community care (extramuralisering) and placing responsibility at the community level (zorg in de buurt). At the same time, because of stricter eligibility criteria, fewer people will be able to avail of formal long-term care.

The following policy developments are expected in the coming years in community-based care.

- Stronger focus on decreasing the demand for professional care (by, for example, increasing prevention, self-management and informal care). The effect of this is likely to be less demand for labour in care.
- Increasing the level of community care (through the separation of residence and healthcare in the AWBZ, the General Act on Exceptional Medical Expenses; see above) and placing responsibility at the community level (zorg en ondersteuning in de buurt; see below). The effect of this is likely to be more demand for labour in community care compared to institutionalised care.
- Increasing efficiency in care. The effect of this is likely to be less demand for labour in care.
- Additional increases in the financial burden on the care consumer. The effect of this is likely to be less demand for labour in care.
- More attention given to macroefficiency of the vocational training. The effect of this is likely to be more supply of labour for care.
- Raising the retirement age. The effect of this is likely to be more supply of labour in general.

Economic factors

As a result of the less positive economic development (1.5% growth per year), employment in the market sector will decrease in the coming years. Therefore, community-based care may become more popular as an employer.

Social factors

The most import social factor is the ageing of the Dutch population. This leads to more demand for care. At the same time, as a consequence of the decline of the number of young people, the influx of young people in vocational training will diminish.

There also seems to be a trend of young people going to preparatory higher education instead of to preparatory vocational training. As such, in the future it seems likely that the availability of people with higher-level qualifications (ISCED 5 and higher) in care and welfare will grow.

Technological and environmental factors

The influence of these factors on the labour market in community care is comparatively limited. There is a trend of new technologies that will assist people with disabilities to be independent (domotics). At the same time, however, experiences show that in the Dutch situation this merely influences the quality of care, not the labour productivity of care workers.

Recruitment and retention of care workers

As mentioned above, in the Netherlands the municipalities are responsible for the provision of household work as well as for contracting it out. They partly grant the household work to cleaning agencies instead of home-care organisations (due to cost savings).

In the Netherlands, patients who need long-term care are distinguished by the level of the care they need and are entitled to. So-called care weight packages (ZZPs) range from 1 to 5. From 1 January 2012, patients in the lowest categories (ZZP 1 and 2) are no longer entitled to institutionalised care. In the future, ZZP 3 and 4 will be excluded too. This shift towards community-based care can also be seen in mental care. The effects of these developments are primarily qualitative: community-based work requires different competences than working in an institutionalised setting.

2 Political and legal frameworks

Regulations and policies on recruitment in community care services

The relevant legislation and regulations in the field of community-based care for adults are as follows.

- **AWBZ (General Act on Exceptional Medical Expenses):** This Act provides for a national insurance for long-term healthcare at home or in an institution. The AWBZ covers all medical costs not compensated by the health insurance. The AWBZ distinguishes between different care functions: personal care, nursing, accompaniment or guidance, treatment, and residence. As mentioned above, in the future the AWBZ will distinguish between the compensation for residence and the other care functions. Furthermore, some care functions of the AWBZ, such as the accompaniment or guidance of patients, will be transferred to the WMO (see below).
- **WMO (Act on Social Support):** This Act arranges for the provisions, help and support required by older people, those with disabilities, and people with mental health problems. The WMO sees to it that every Dutch citizen continues to be able to participate in society and to live as independently as possible. Municipalities are responsible for the implementation of this Act and each municipality can have a different approach regarding its implementation.
- **PGB (Personal Budget):** With a PGB, people in need of health or social care, or both, as a result of illness, disability or old age can purchase this care themselves. They can call in care workers in the service of regular care institutions or self-employed care workers. The PGB is financed by the AWBZ and the WMO. As a result of the Dutch government's cost reduction policies, in 2012 only people eligible for care with residence – community-based care – are eligible for this budget. In other words, only those who need so much care that living in a care institution is recommended are eligible. As of 2013, more people will be eligible for a PGB.

Recruitment strategies for community care workers

The Dutch cabinet considers community-based health and social care (zorg en ondersteuning in de buurt) as a top priority. The increase in the number of chronic patients combined with a shrinking labour market and rising costs require a different set-up for the health and social care system.

The Ministry of Health, Welfare and Sports wants to organise community-based health and social care in cooperation with the sector. It prevents unnecessary appeals to care, especially forms of care that are too expensive. Integral, local, made-to-measure care leads to better services for the citizen as well as to identifying problems earlier. As such, the accompaniment or guidance of patients, which at the moment is part of the AWBZ, will be transferred to the WMO and thus decentralised to the municipalities.

An important element of the plans is removing impediments for financing. The Dutch Care Authority (Nederlandse Zorgautoriteit, NZa) is evaluating the financing of primary healthcare. Existing financial partitions between systems will be adapted if they stand in the way of proper, effective and efficient care. This also concerns guaranteeing the use of district nurses.

Innovative initiatives help to strengthen the coherence between different levels of health and social care. Therefore, obstacles for financing and the entry of new forms of care, such as e-health, will be removed.

The intention of the Ministry of Health, Welfare and Sports was to present a plan of action in the course of 2012 that would map out the legal, financial, organisational and insurance–technical measures necessary for achieving more community-based health and social care (Ministerie van VWS, 2011b).

The emphasis of the broad policies and strategies concerning community care workers is primarily on recruitment. The retention of community care workers still receives insufficient attention.

The Innovation Care Professions and Education Committee (Commissie Innovatie Zorgberoepen en Opleidingen, CIZO) has recently been established. This committee will advise on the desired development of professions and education in healthcare. Starting points are the social and technological developments in healthcare and the future demand for healthcare. Other points of interest include new professions and reorganising the existing tasks of healthcare workers.

3 Structural framework, funding and actors involved

Employment in the care sector

Table 1: Total employment in health and social care in the Netherlands, 2011 (in jobs and FTE, x 1.000)

Branch	Jobs (x 1.000)	FTE x 1.000
University hospitals	74.6	57.8
Other hospitals	206.2	158.7
Care for people with mental health problems	**88.1**	**69.3**
Nursing homes and homes for the elderly	249.5	164.0
Care for people with disabilities	**160.8**	**113.5**
Home-care services	**192.8**	**92.0**
Other healthcare	162.6	109.1
Welfare services	**71.9**	**50.1**
Youth welfare work	35.3	27.6
Child care	107.1	70.7
Total health and social care	1.348.9	

Source: Panteia and SEOR (2012).

The relevant branches for this study in particular are mental healthcare, care for people with disabilities, home-care services and welfare services. These branches account for 88,000, 161,000, 193,000 and 72,000 jobs, respectively, giving a total of 514,000 jobs overall. Only some of these jobs are in community-based care for adults with disabilities. By definition, home-care services are community based, but they are only partly aimed at the target group of adults with disabilities. The other three branches are only partly community based and also only partly aimed at the target group. Furthermore, one and the same care worker can supply care in a community-based as well as in an institutionalised setting and care for different age groups.

An indication of the size of the community-based care sector is the share of patients who are eligible for community-based AWBZ care. On 1 July 2012, 427,980 AWBZ patients (38%) were eligible for the CIZ community-based (extramurale) care and 699,855 patients (62%) for institutionalised (intramurale) care (CIZ, 2012). However, part of the latter group still resides at home.

Another indication of the size of the community-based care sector is the number of establishments and employees in NACE code 88.10 (social work activities without accommodation for older people and those with disabilities): on 1 January 2012, there was a total of 2,055 establishments with approximately 132,300 employees, according to the highest rough estimate.[2]

Funding structure

The Dutch care system is globally financed on the basis of three Acts. Besides the AWBZ and the WMO, the third relevant Act is the Health Insurance Act (Zorgverzekeringswet). The Basic Health Insurance is compulsory for anyone who lives or works in the Netherlands. It covers the

[2] This rough estimation by Panteia is based on data from the Dutch Central Statistical Office on the number of establishments and *classes* of the number of employees in NACE 88.10. Estimates are: lowest (18,900 employees), middle (39,585 employees), highest (132,270 employees).

costs for a family doctor, hospital and pharmacy. For other costs (such as for alternative medicine or dentistry), people can opt for supplementary health insurance.

Community-based care for adults with disabilities is mainly financed by the AWBZ and WMO. The budget for the WMO has been cut. For many municipalities, this is a substantial problem.

Organisations, actors and stakeholders involved

The main relevant parties are:

- the Ministry of Health, Welfare and Sports (Ministerie van VWS);
- national employers' organisations (Actiz, GGZ Nederland, VGN, MO Groep, BTN, Jeugdzorg Nederland and Per Saldo, which represents the self-employed), trade unions and occupational organisations in health and social care;
- the so-called Labour Market and Education Funds (A+O fondsen) in health and social care (on behalf of the employers' organisations and trade unions responsible for the development and implementation of sectoral labour market policy and the distribution of ESF funds amongst care institutions);
- regional cooperative bodies of employers in health and social care under the umbrella of the national organisation RegioPlus, which is responsible for the development and implementation of regional sectoral labour market policy;
- Calibris, a knowledge centre in the field of practical training in health and social care and sports, responsible for recognising institutions allowed to offer trainee posts and for deciding on qualifications in vocational training;
- the Dutch employment services (UWV).

4 Strategies for recruiting and retaining employees

Targeting labour reserves

Initiatives in the Netherlands are targeting known labour reserves such as unemployed people and partially disabled people registered with the UWV, other job-seekers and the so-called silent labour reserves.

- With regard to known labour reserves, two running agreements deserve to be mentioned: firstly, the Sector Arrangement Health and Social Care (Sectorarrangement Zorg en Welzijn) between RegioPlus and UWV, which aims at leading partially disabled people to a job in care; and secondly, the agreement between the employers' organisation in mental healthcare (GGZ Nederland) and UWV, which aims at stimulating the labour participation of people with mental health problems. Besides that, some mental healthcare organisations employ former patients themselves as 'hands-on' experts (in the care and treatment of drugs addicts, for example, especially in a coaching role).
- Another group of job-seekers are zij-instromers – people currently employed in other sectors but willing to work in care (again). At the moment, the largest pension fund in the Dutch care sector (PGGM) conducts a survey amongst former participants. The aim is to find out which sector they are currently working in and whether or not they intend to return to work in the care sector (and under which conditions). Employees with an educational background in care in surplus sectors (such as the government) who are made redundant or risk becoming redundant are also relevant. Next, there are cross-border workers and labour migrants. At the moment, an increasing number of new temporary employment agencies recruit temporary care workers from southern European countries, especially Spain.
- Finally, in the Netherlands there are still some silent labour reserves (mainly women, but also people aged over 55 and young people aged 18 to 25 years) (EIM, 2003). However, as a result of the increasing labour participation of women, this source of labour supply will eventually dry up.

Promoting education and training

There are currently several campaigns to attract young people to be trained for and work in community-based care (such as Open Armen and Jij bent de gehandicaptenzorg in home-care services and care for people with disabilities, respectively). Furthermore, at the moment a fair amount of secondary school pupils do their compulsory social work placement (maatschappelijke stage) in care. The Rutte II cabinet, however, intends to stop this social work placement. Other pupils also have secondary jobs in the sector.

The sector also aims at further professionalisation and by so doing raising the status of study and work in care. An example is the development of a new, specific professional profile for district nurses (Expertisegebied wijkverpleegkundige) by the V&VN (the Dutch professional association of nurses).

Furthermore, attempts are being made to raise the success rate of education in care. In part, these activities aim at improving the quality of practical training and its supervision. Examples are the Care Practical Training Fund (Stagefonds Zorg) and the new concept of community-based practical training in care (WijkLeerbedrijf – Neighbourhood Training Company) developed by Calibris. There are also new care education concepts, such as the Care Vocational College (Vakcollege Zorg), which provides for ongoing learning between lower secondary and secondary professional education in care. From the start, pupils at this college are offered a high amount of practical training. These new concepts not only contribute to the success rates of education, but also improve the connection between education and the labour market.

Improving the situation of current employees

Firstly, activities in this field aim at optimising the employability of care workers through lifelong learning and mobility. The so-called EVC procedures, which recognise competences attained on the job, are important in this respect. Employees' efforts can also be improved by the better scheduling of working times. In addition, forms of self-scheduling also contribute to a better work–life balance, as research in Dutch mental care demonstrates (O&O fonds GGZ, 2012).

Secondly, attempts are made to retain current employees in the care sector by the following means.

- **Further improving the terms of employment and working conditions:** At the centre of attention is the pressure of work and aggression. The Dutch Action Plan Working Safe in Care (Veilig Werken in de Zorg) aims at better preparing students and employees in care for handling aggression and violence by patients (or their relatives and friends). Care workers can now anonymously report aggression using a number instead of name and address. As of April 2012, pressure of work and aggression is one of the priorities of the Dutch labour inspectorate.
- **Stimulating employees' self-development:** Several initiatives aim at giving more space (autonomy, responsibility and so on) to the professional. The self-steering district teams of the Dutch Buurtzorg organisation are good examples, as are the Excellent Care (Excellente Zorg) and In For Care (In voor Zorg) national programmes.
- **Ageing policies (duurzaam inzetbaarheidsbeleid):** Ageing policies aim at optimising the employability of care workers during their entire career. For example, in the past older care workers were entitled to extra days off. Recently, in a number of collective labour agreements in care, those extra days off for older care workers have been replaced by a stage-of-life budget (levensfasebudget) for all employees. All employees receive a number of extra leave hours per year, which they can use in that year or save for another time in their career.
- **Diversity policies (diversiteitsbeleid):** In care, employees from countries other than the Netherlands are still under-represented. In the Intercultural Foundation programme (Intercultureel Fundament), the employers' organisations in home-care services and care for people with disabilities work together to strengthen the cultural sensitivity of labour organisations in these branches. The aim is to reach, secure and retain patients as well as employees from immigrant population groups.

Improving operational management and labour productivity

Firstly, operational management and labour productivity can be improved by optimising the working processes by achieving the following goals.

- **Reducing the overhead and management layers and giving the management a more facilitating role:** For instance, the Dutch Buurtzorg organisation is characterised by a very flat organisational structure.
- **Diminishing the administrative burden:** Currently, as part of the Experimental Low Regulation- Institutions (Experiment Regelarme Instellingen), 28 labour organisations in the Dutch care sector are working in a setting with considerably fewer and adapted regulations. They are also allowed to decide on the amount and type of care for some categories of patients themselves (patients younger than 80 years and patients in community-based care).
- **Shorter working shifts:** At present, in the branch nursing homes and homes for the elderly, there are already shorter working shifts around the rush hours. This leads to efficiency gains.

Secondly, improvement can be achieved by adjusting the content of functions by reorganising tasks, function differentiation, and function creation or job carving, for example. In the framework of community-based mental healthcare, family doctors work together with nurses

with experience in the field of mental healthcare. At the same time, however, a broadening of functions can be seen. In some organisations in home-care services and mental healthcare, nurses also perform personal care tasks and the like.

Thirdly, operational management and labour productivity can be improved by technological innovations. With regard to community-based care especially, technological innovations in the field of e-health, such as telecare and online information, communication and treatment, are relevant. Until now, in the Netherlands telecare has primarily been aimed at autochthonous senior citizens. In an experiment in Amsterdam recently, experience has been gained with different target groups, such as people with intellectual disabilities, those with mental health problems and older people from minority groups (UvA, 2011).

The Dutch cabinet aims at stimulating the use of e-health applications by, for example, monitoring developments, by adjusting regulations when necessary and by financing the development and implementation of standards in this field.

Lastly, improvement can be made by 'moving' care activities. The Dutch cabinet aims at optimising the tasks in the chain of care (ketenzorg) and care nearby citizens (zorg en ondersteuning in de buurt; see above). This also means a stronger emphasis on community-based care. In this respect, an important coordinating role is granted for family doctors and district nurses. In the framework of the national programme Visible Link (Zichtbare Schakel), extra district nurses were hired in urban and rural districts with socioeconomic and health disadvantages. This turned out to be successful in terms of cost reductions, labour reduction and well-being gains. As a result, the Dutch cabinet has decided to structurally support local projects around district nursing services.

5 Outcomes, results and impact of policies

Effectiveness of current instruments and policies

Not all of the above-mentioned initiatives have been evaluated yet. In addition, in general it is not easy to assess the net effect of labour market policies. Generally speaking, successful solutions for expected labour shortages in community-based healthcare for adults with disabilities are primarily to be found in the following.

- The recruitment of new employees by attracting young people to the sector, raising the success rate of education, recruiting former care workers, recruiting redundant workers in surplus sectors and recruiting labour migrants, mainly from southern Europe.
- The retention of current employees by being an attractive employer and by offering the potential for employees' self-development.
- The education of current employees through lifelong learning.
- Adaptations in the organisation of work by optimising working processes and adapting the content of functions.
- Using new labour-saving technological possibilities, especially in the field of telecare and online information, communication and treatment.

The attempts to upgrade known labour reserves such as unemployed people and the partially disabled from intermediate vocational education level 2 to intermediate vocational education level 3 seem to be less successful. In care, the work at level 3 requires some additional competences, such as the ability to abstract and report, that people on level 2 are often missing. There are more possibilities in this respect at higher levels.

In the coming years, it is more likely that the Dutch social care sector will have to cope with a surplus of labour. Helped by social plans and From Work to Work policies (Van Werk Naar Werk beleid), redundant employees can find their way to other branches, within or without the care sector.

6 Key trends, issues and policy pointers

This report gave a brief overview of the Dutch labour market policy in community-based care to support adults with disabilities, illustrated by three case studies (see Annex 1).

National context

Community care workers in the Netherlands work mainly in home-care services, community-based mental healthcare, community-based care for people with disabilities and community-based social care. Companies operating in the cleaning branch are also active in these fields.

Partly as result of ageing and the resultant increased demand for care, the costs of the Dutch care system are high and growing. In general, community care is less expensive than institutional care. Cost reduction policies are increasing the already high level of community care and place responsibility at the community level. Another rationale for encouraging community care is increasing patients' ability to live and do things independently for as long as possible.

At the moment, the shortages in community-based healthcare are relatively small, but these shortages will probably increase in the coming years. Due to the Dutch government's cost reduction policies, there is and will be a surplus of labour in social care. As a result of the less positive economic development, employment in the market sector will decrease in the future. Therefore, community-based care will be more popular as a source of employment.

Policy and legal frameworks

Relevant legislation and regulations in the field of community-based care for adults are:

- AWBZ (General Act on Exceptional Medical Expenses), which provides for a national insurance for long-term healthcare (at home or in an institution), covering all medical costs not compensated by the health insurance;
- WMO (Act on Social Support, responsibility of the municipalities), which arranges for the provisions, help and support required by people with intellectual disabilities, those with mental health problems and older people;
- PGB (Personal Budget), which gives people in need of health or social care (as a result of illness, disability or old age) the opportunity to purchase this care themselves.

The Dutch cabinet considers community-based health and social care as a top priority. Integral, local, made-to-measure care leads to better services for the citizen as well as to identifying problems earlier. As such, the accompaniment and guidance of patients, which at the moment is part of the AWBZ, will be transferred to the WMO and thus decentralised to the municipalities.

The emphasis in the broad policies and strategies concerning community care workers is primarily on recruitment. The retention of community care workers still receives insufficient attention.

Structural framework and funding structure

The branches of mental healthcare, care for people with disabilities, home-care services and welfare service account for 88,000, 161,000, 193,000 and 72,000 jobs respectively (514,000 jobs in total). Only some of these jobs are exclusively in community-based care for adults with disabilities. An indication of the share of community-based care in total care is the percentage of patients who are eligible for community-based AWBZ care, which is 38% (CIZ, 2012).

The Dutch care system is globally financed on the basis of the AWBZ, the WMO and the Basic Health Insurance Act (Zorgverzekeringswet). The Basic Health Insurance is compulsory for

anyone who lives or works in the Netherlands. It covers the costs for a family doctor, hospital and pharmacy. For other costs, people can opt for supplementary health insurance. Community-based care for adults with disabilities is mainly financed by the AWBZ and WMO. The budget for the WMO has been cut. Apart from public care, there is also private care in the Netherlands.

The main parties involved in the labour market management of community care are:

- the Ministry of Health, Welfare and Sports;
- national employers' organisations, trade unions and occupational organisations in health and social care;
- labour market and education funds (A+O fondsen) in health and social care;
- regional cooperative bodies of employers in health and social care under the umbrella of the national organisation RegioPlus;
- Calibris, the knowledge centre in the field of practical training in health and social care and sports;
- UWV, the Dutch employment services.

Strategies used to recruit and retain employees

There is a wide range of concrete initiatives to recruit and retain employees in community-based care in the Netherlands. Firstly, there are initiatives targeting labour reserves such as unemployed people and partially disabled people registered with UWV), other job-seekers and the so-called silent labour reserves. A second category of initiatives aims at stimulating and facilitating care education by, for example, image campaigns, professionalisation, raising the status of care work and raising the success rate of care education. Thirdly, there are initiatives aiming at improving operational management and labour productivity by optimising the working process, adjusting the content of functions, technological innovations (such as e-health) and by optimising the tasks in the chain of care. A final category of initiatives aims at improving the situation of current employees by optimising the employability of care workers (through lifelong learning and mobility), further improving the terms of employment and working conditions, increasing employees' self-development, ageing policies and diversity policies.

Outcome and impact of policies

Generally speaking, successful solutions for the expected labour shortages in community-based healthcare for adults with disabilities are primarily to be found in:

- the recruitment of new employees;
- the retention of current employees;
- the education of current employees;
- adaptations in the organisation of work;
- using new labour-saving technological possibilities.

The attempts to upgrade known labour reserves from intermediate vocational education level 2 to level 3 seem to be less successful. In care, the work at level 3 requires some additional competences that people at level 2 are often missing. At higher levels, there are more possibilities in this respect.

In the coming years, it is likely that the Dutch social care sector will have to cope with a surplus of labour. Helped by social plans and From Work to Work policies (Van Werk Naar Werk beleid), redundant employees can find their way to other branches (within or outside of the care

sector).

Case studies for the Netherlands

The following three case studies (Annex 1) illustrate the Dutch labour market policy in community-based care to support adults with disabilities.

- The Neighbourhood Training Company (WijkLeerbedrijf, WLB), a new concept of practical training in which health and social care students at a lower qualification level acquire work experience in their own residential district by doing odd jobs for vulnerable citizens.
- The Dutch national programme Visible Link (Zichtbare schakel) (2009–2012), promoting the qualitative and (cost) effective deployment of highly skilled 'new-style' district nurses with a coordinating role, especially in problem districts.
- A new concept for nursing and care at home, developed by the organisation Buurtzorg Nederland (Netherlands Neighbourhood Care), in which small self-steering district teams of highly skilled care workers have full responsibility for the nursing and care of clients at home.

These three initiatives have already proven to be successful in terms of reaching quantitative targets, sustainability (structurally embedding the successful results) and transferability (transferring the approach to other contexts). This is partly due to the favourable social and political climate in the Netherlands for initiatives in the field of labour market policy in community-based care and partly to the intrinsic characteristics of the initiatives themselves.

Recommendations

General

A wide range of strategies and measures is already being deployed to combat labour market discrepancies in community-based care in the Netherlands. Each of the various strategies (and measures within these strategies) as described in this report has its own merits. Given these complementarities, connecting the various measures of the strategies in an integral approach is highly advisable. The most promising strategies for future labour shortages in community-based care are:

- the recruitment of new employees (young people, people returning to work, unemployed people, labour migrants, and so on) and the retention of current employees (by being an attractive employer and by offering the potential for employees' self-development);
- the education of current employees through lifelong learning;
- labour-saving social innovations such as optimising working processes and adapting the content of functions, and technological innovations , especially in the field of assistive technology and telecare.

Case studies

In the Netherlands, much attention is being paid to improving the attractiveness of vocational education in health and social care. Furthermore, district nursing and self-steering are high on the agenda. From the three cases studied, the following lessons can be learnt.

The community-based practical training (offered by the WLBs) is an inspiring, on-the-job learn–work environment for underprivileged health and social care students at the lower qualification levels. As a result, more students finish their education, a larger share of them move on to a higher level of education and a larger part of the qualified school-leavers ultimately choose a career in community-based health and social care.

Prerequisites for the success of community-based practical training in health and social care are commitment and co-financing by the municipality and close cooperation of the other parties

involved. The coordination and agreements between these parties require permanent attention. Furthermore, the demand side has to take the lead. Of great importance is a made-to-measure approach in which the right student is matched with the right client (preferably by an intermediary specialised in this field). Finally, the training approach has to be well considered – the emphasis must be on practical training and not on theory, there must be education on the job and on location as well as intensive coaching and individual attention.

The Visible Link (Zichtbare schakel) programme aims at 'new-style' district nurses. Besides the regular healthcare tasks, the district nurse also has tasks in the fields of coordination and direction, advice and referring, observing and problem analysis. As such, connections are being made with relevant policy areas such as housing, employment and integration.

At the start of local projects aimed at the recruitment and deployment of district nurses, much attention has to be paid to obtaining a broad basis in the organisations involved, at managerial level as well as implementing level and cooperation and commitment of other care suppliers in the district, such as general practitioners. At the same time, 'island formation', overlap and fragmentation in care supply at district level have to be prevented.

The possible limited availability of trained district nurses can be solved by upgrading less qualified care workers or recruiting employees from other disciplines. The coordinating role of the district nurse also requires a certain degree of freedom of rules.

Self-steering district teams of nurses or orderlies go one step further. This concept of Netherlands Neighbourhood Care – giving full responsibility for the nursing or care of clients at home to the team members themselves – is very promising and highly recommendable. Potential employees turn out to be highly attracted to this concept. It contributes to professional as well as personal growth. In addition, as a result of the flat ('lean and mean') organisational structure, it leads to less administrative burden, less pressure of work and thus more time for direct client contacts and better care. Preconditions for adequately functioning self-steering teams are the team's authority to make its own decisions within clear frames, agreed upon with the management; well-balanced composition of the team with good mutual relations and mutual agreement on the division of tasks; regular solution-orientated meetings to discuss work in which decisions are taken according to the consensus principle; and joint responsibility for organisational tasks and group results.

In order to prevent overburdening as a result of too much commitment of the team members, especially in the 'pioneering phase', clear agreements have to be made on who is accessible at which point in time. In this respect, an open attitude and communication are also important.

Sustainability

In general, the sustainability of labour market initiatives deserves particular attention, especially in the case of subsidised project-based initiatives. Usually, the subsidy granted for project-based initiatives is temporary. Therefore, in many cases alternative funds have to be found after the project period. Furthermore, the coordinating activities of the project management have to be secured and there has to be a party willing to continue to carry the load.

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Annex 1: Case studies

This annex presents the results of the three Dutch case studies on initiatives in the field of labour market policies in community-based care to support adults with disabilities. The three case studies are:

Case study 1: Neighbourhood Training Company (WLB)

Case study 2: Visible Link

Case study 3: Netherlands Neighbourhood Care

Each case study includes a description of the initiative, definition of the problem, approach and implementation and contextual factors. There then follows an analysis of the outcomes and results of the initiative. Finally, the lessons learnt and factors regarding the sustainability and transferability of the initiative are presented.

Case study 1: Neighbourhood Training Company (WLB)

Description of the initiative

This case study focuses on the Neighbourhood Training Company initiative (WijkLeerbedrijf, WLB). The WLB is an instrument to help underprivileged people get a job in health and social care. It is a new concept of community-based practical training in health and social care that guides trainees in acquiring work experience related to their education (healthcare and welfare, intermediate vocational education levels 1 and 2) in their own residential district. Trainees do odd jobs that residents can no longer do themselves but that they do not receive care for from the municipality. The WLB initiative is developed at national level by Calibris. At the moment there are WLBs in various districts or municipalities in the Netherlands.

Overall objectives

The aims of this initiative are primarily labour market orientated through providing affordable social care to vulnerable citizens, especially in problem districts:

- offering an inspiring practical learning environment for underprivileged people (especially young people);
- providing a larger supply of trainee posts on healthcare and welfare intermediate vocational education levels 1 and 2;
- stimulating inflow into healthcare and welfare education on intermediate vocational education levels 1 and 2 and encouraging more people to move on to level 3;
- improving output of healthcare and welfare education (a stronger tie between students and school, fewer dropouts, more school-leavers with a starting qualification – at least intermediate vocational education level 2);
- less youth unemployment.

Combating social problems are seen as positive side-effects.

Definition of the problem

Policy background

The initiator of the WLB is Calibris, the Dutch knowledge centre in the field of practical training in healthcare, welfare and sports. Calibris, a public agency, has responsibility for establishing terms of qualification and assessing companies offering practical training posts. The organisation aims at a seamless connection between vocational training and professional practice by developing, facilitating and implementing effective initiatives, among other things.

Role of the social partners

Representatives of employers' organisations, trade unions and educational organisations in the field of healthcare, welfare and sports are on the board of Calibris, so the social partners are directly involved in the development and implementation of the WLB.

Issue at stake

The WLB initiative has two positive outcomes. Firstly, the instrument addresses labour market problems: lack of trainee posts, a relatively large number of dropouts (especially at the lower levels of vocational training) and combating the expected deficit in highly skilled care and

health workers. Secondly, it combats social problems: the situation of vulnerable citizens who are in need of but formally not eligible for healthcare and welfare, and the lack of social cohesion, especially in problem districts.

Approach and implementation

Overall approach

The WLB helps trainees acquire work experience in health and social care in their own residential district. Through attractive trainee posts and individual coaching, the WLB helps young people, people returning to work (especially women), and those looking to change employment sectors to get jobs in health and social care. The WLB trainees offer small-scale, accessible, affordable health and particularly social care to vulnerable citizens living in their own district. The citizens concerned can stay independent and the trainees get acquainted with working in health and social care at intermediate vocational education level 1 or 2. After achieving these qualifications, they can move on to a health and social care education at intermediate vocational education level 3, a level where substantial labour shortages are expected (Calibris, 2011). The WLB initiative primarily aims at districts with an accumulation of social problems.

Aim of initiative

The assumption is that giving health and social care students work experience in their own neighbourhood motivates them. More students are expected to successfully finish their education at intermediate vocational education level 1 and 2 and a larger proportion will move on to intermediate vocational education level 3. WLB thus contributes to the output of the education concerned and a larger part of qualified school-leavers will ultimately choose a career in healthcare and welfare. Therefore, the WLB initiative is believed to increase the recruitment of personnel in community-based care and helps to combat youth unemployment.

Recruitment versus retention

The WLB initiative is primarily aimed at increasing the recruitment of personnel.

Specific target groups

The WLB initiative is primarily aimed at underprivileged young people, people returning to work (especially women), and those looking to change employment sectors.

Formal versus non-formal employment

The WLB initiative is not aimed at a transfer of non-formal to formal employment.

Project implementation

Programme level

The WLB initiative is developed, facilitated and implemented by the Calibris Advice (Calibris Advies) branch. In close cooperation with its social partners (including business, government, education, and health social care parties), Calibris Advice developed and implements the WLB initiative to create a better balance between supply and demand on the labour market. To maintain quality, Calibris Advice works with clear criteria. Firstly, close cooperation between the parties involved is a prerequisite. All parties must commit to the WLB, including financially. Calibris itself can appeal to funds for specific target groups and can support municipalities in acquiring subsidies from the European Social Fund (ESF). Secondly, commitment and co-financing from the municipality are indispensable. Thirdly, the WLB has to respond to labour market developments (demand orientation).

Project level: Neighbourhood Training Company in Utrecht Overvecht

WLBs are increasingly active in more municipalities. As an example, the box below describes the WLB Zorg & Zo (literally: 'care and that sort of thing') in the municipality of Utrecht.

WLB Zorg & Zo

Zorg & Zo started in November 2011 and serves the following client groups in the Overvecht district in the municipality of Utrecht: people over 55; leergezinnen (learning families)[3]; health and social care institutions (odd jobs); rehabilitation clients; initiators of community projects; and schools and associations (odd jobs).

Next to pacesetter Calibris, various local organisations in the field of health and social care and the local intermediate vocational education institute are involved in Zorg & Zo. The municipality of Utrecht contributes €70,000 to Zorg & Zo.

At the moment, Zorg & Zo has two staff members who work closely together with the organisations mentioned above. One of them is a teacher at ROC Midden Nederland, the other is a labour broker (werkmakelaar) and practical trainer. The staff members match clients with suitable trainees; keep in contact with the clients; discuss the client visits with the trainees (in advance and afterwards); discuss the experiences of trainees during peer review sessions; and guide and, if necessary, support the trainees in accomplishing their school tasks.

Zorg & Zo is aimed at health and social care students at ROC Midden-Nederland on intermediate vocational education level 2. The students have to be over 17 and willing to gain experience in healthcare and welfare. There are 20–25 trainee posts. The trainees go to school three days a week and do a work placement at the WLB for the remaining two days. The work placement periods vary from 15 to 20 weeks. Trainees do odd jobs at people's home, such as household work; activities such as accompanying people to the library, the doctor, shops or playing games, reading the paper, going for a walk or just being there; and helping the children by accompanying them to the playground or library. In addition, they do odd jobs at various organisations, such as playgroups, morning and after-school childcare, small-scale residential centres for the elderly, activity centres (sport and gaming activities), nursing homes and homes for older people.

Monitoring and evaluation

This WLB initiative has not yet been evaluated. However, in addition to the case of Utrecht (as described above), Calibris points to five other good practice examples in the municipalities of Den Haag, Dordrecht, Haarlem, Hengelo and Leiden (factsheets with some basic information are available for these).[4]

Contextual factors

There has been a trend towards more community-based care and less institutionalised care in the Netherlands in the past few years. At the same time, fewer people are eligible for formal long-term care. These trends will continue, which means more potential clients for the WLBs. In

[3] A leergezin is a formal trainee post at a private family. In this small setting, health and social care students at the lower qualification levels (1 and 2) learn the competences (knowledge, attitude and skills) required for the job they are studying for. The leergezin can be a family with or without children, older people, single people or adults with disabilities.

[4] http://www.calibris.nl/Strategisch-opleiden/Stageconcepten/WijkLeerbedrijf

addition, the Rutte II Dutch cabinet plans to abolish the compulsory social work placements (maatschappelijke stages) for secondary school pupils as of 2015. The WLBs can partly fill this gap with its services.

Concerning vocational education, the following policy developments are relevant.

- The Dutch Ministry of Education, Cultural Affairs and Sciences is developing a so-called 'macroefficiency' policy for intermediate vocational education that focuses on vocational education in sectors with many labour market prospects (such as care) instead of sectors with fewer prospects.
- There is a general tendency in vocational training towards more practical training.
- As of 2007–2008, care institutions with trainee posts for students at intermediate vocational level and higher vocational level can appeal to the Care Work Placement Fund (Stagefonds Zorg) for a contribution towards the cost of coaching trainees. Thanks to this fund, in 2010 about 1,400 care institutions were able to arrange trainee posts for nearly 100,000 students. This fund will continue in the years to come.
- SBB, the umbrella organisation for knowledge centres in the field of practical training (including Calibris), has started an initiative aimed at recruiting and retaining trainee posts. As of 1 January 2013, this initiative will be intensified.

In all, the developments listed above form favourable conditions for the WLB.

Outcomes and results

Type and numbers of jobs created

This is not applicable, since the WLB initiative is not aimed at creating jobs, but rather trainee posts.

Other relevant outcomes

Number of WLBs: Apart from the six good practice examples mentioned above, at the moment there are WLBs in Amersfoort, Rotterdam, Veenendaal and Zuid-Kennemerland.

Number of trainee positions and trainees: Calibris points to six good practice cases of WLB implementation. The WLBs in the cities of Dordrecht, Haarlem, Hengelo, Leiden and Utrecht all started activities in 2011 and each have between 15 and 22 trainee posts. The exceptional case is the WLB in the Hague, which started in January 2010 and has nearly 100 trainee posts.

Main results

The various parties involved in the WLB each have different interests. According to Calibris, that is exactly why the WLB instrument is effective, as everyone benefits: there are more professionals in health and social care; those further removed from the labour market become qualified; there is more social care at district level; and less unemployment among underprivileged groups. In all, Calibris believes the investments in the WLB are profitable, both from a social and economic perspective. Underprivileged people are prepared for the labour market, contribute to the economy and no longer depend on benefits. In the long run, this is a substantial gain as well as a substantial saving (Calibris, 2011).

Lessons learnt

Success and fail factors

From the factsheets for the six good practice examples, a number of success factors and potential fail factors can be derived.

Success factors:

- Calibris is the independent driver of the WLB;
- shared need – each of the parties has its own interest(s). Combining these interests in a WLB has synergistic effects;
- financial commitment and good cooperation, coordination and agreements between the parties involved;
- the initiative is demand-led: The focus is first and foremost on what the neighbourhood needs and the WLB must provide for these needs through its trainees;
- accessibility: The WLB is an attainable service for residents;
- number of trainees: There must be enough trainees to provide for the care required in the neighbourhood;
- the WLB is a made-to-measure approach, matching the right student with the right client. The labour broker (werkmakelaar) of the WLB plays an important role;
- a well-considered training approach: The WLB is characterised by more practical training and less theory; education on the job and on location; a familiar trainee post environment (more motivation); intensive coaching and individual attention; and possibilities for qualified students (intermediate vocational education levels 1 and 2) to move on to healthcare and welfare education at a higher level (level 3).

The relatively large number of parties involved in the WLB is a potential fail factor; coordination between these parties demands permanent attention. Another potential fail factor is the dependence on ESF subsidies and co-financing by the municipality. Finally, the vulnerability of the target group is another potential fail factor. The trainees involved ask for made-to-measure trainee posts, intensive coaching and personal attention, which require a lot of time and money.

Sustainability and transferability

In the case of the WLBs, sustainability is a point of particular interest; at present WLBs partly depend on project subsidies and are co-financed by municipalities. As the WLBs are a fairly new phenomenon, it is too early to comment on the sustainability of the initiative.

The concept appears to be highly transferable to other districts or municipalities, given the establishment of a relatively large number of WLBs in different parts of the country within a couple of years.

Conclusions

At the centre of this case study was the WLB, which sets up trainee posts in the healthcare and welfare sector so that underprivileged people (especially young people) can gain work experience in the sector at intermediate vocational education levels 1 and 2. The work takes place in the trainee's own district as the familiarity of the neighbourhood is believed to increase motivation to complete the qualification. A larger portion of young people are expected to move on to intermediate vocational education level 3 so that ultimately more school-leavers choose a career in healthcare and welfare. Thus, the WLB initiative is believed to enhance the recruitment of personnel in community-based care and to contribute to combating youth unemployment. Positive side-effects include higher supplies of accessible and affordable care for vulnerable citizens, while in the long run, underprivileged individuals are prepared for the labour market, contribute to the economy and do not depend on benefits.

So far, the WLB initiative has proven to be successful. In ever more municipalities, business, health and social care, education and government work together in a WLB and all parties involved benefit. While the sustainability of the project must be more closely examined, its transferability to other contexts has proven to be high.

Case study 2: Visible Link

Description of the initiative

Visible Link (Zichtbare schakel) is a national programme, commissioned by the Ministry of Health, Welfare and Sports and the Ministry of the Interior. ZonMw was responsible for the implementation of the programme,[5] which ran from 2009 until the end of 2012. In the framework of the programme, a target of 250 extra, versatile and skilled district nurses were recruited and deployed within districts. The total budget available was €40,000,000.

Overall objectives

Visible Link promotes the qualitative and (cost) effective deployment of highly skilled district nurses, especially in problem districts (such as urban or rural districts with socioeconomic and health disadvantages). The aim of the district nurse is to solve multiple problems of citizens (especially vulnerable groups) by connecting various aid organisations in the field of housing, (preventative) healthcare and welfare at the district level. Besides coordinating healthcare and welfare, the district nurses also provide for domiciliary care themselves. Ultimately, Visible Link aims at improving coherent care at district level.

Definition of the problem

Policy background

The immediate background for developing the Visible Link programme is the acceptance in September 2008 of a Lower House resolution. In this resolution, the Lower House asked for the 'return' of the district nurse, to begin within problem districts.

Role of the social partners

The social partners did not play a direct, active role.

Issue at stake

The central problem Visible Link addresses is the lack of coherence between housing, (preventative) healthcare and welfare at the district level. As a result, quality of life is often suboptimal, especially in problem districts.

Approach and implementation

Overall approach

Until the end of the 1960s, the district nurse (wijkzuster), with broader health and social care tasks, was a respected and valued member of a community. Over time, however, socioeconomic shifts and developments led to the eventual splitting and reassignment of the district nurse's various tasks to other specialised home-care workers. This was assumed to be a more efficient and less expensive method of working. Given recent demographic and policy trends, however, the last five years witnessed a revival in the district nurse concept. The increasing numbers of vulnerable elderly people as well as the preference to allow (young) people with disabilities to

[5] ZonMw is an organisation aimed at improving prevention, health and care by stimulating and financing research, development and implementation. Funds come from the Ministry of Health, Welfare and Sports and NWO (the Dutch Organisation for Scientific Research). See www.zonmw.nl.

live independently as long as possible make the district nurse an important link between the client on the one hand and health and social care organisations on the other.

The 'new-style' district nurse that the Visible Link programme aims at has an even broader function than the 'old-style' district nurse described above. In addition to the regular healthcare tasks, the district nurse also has tasks in such fields as housing, employment and integration. The tasks and functions of the district nurse are:

- early observing and referring;
- care and advice – connecting clients with the right help;
- tailoring health or other measures to the needs of clients or neighbourhoods as a whole;
- registering and follow-up checks;
- monitoring policy-relevant information as feedback for local health policy.

In order to adequately fulfil these tasks and functions, it is important that the district nurse is part of an organisational unit at district level, which supports them in making the necessary connections.

Aim of initiative

The idea behind the Visible Link initiative is that with the deployment of 250 extra district nurses:

- the integrated approach between housing, (preventative) healthcare and welfare will be improved;
- the connection between demand and supply of care and services for citizens at district level and its accessibility will be optimised;
- a system of care and services in the neighbourhood suited to the needs of citizens, especially vulnerable citizens, will be established.

Recruitment versus retention

The programme is primarily aimed at recruiting extra district nurses. However, by making the job of the district nurse more attractive, it also aims at retaining care personnel.

Specific target groups

The programme does not aim at specific target groups.

Formal versus non-formal employment

The programme does not aim at a transfer of non-formal to formal employment.

Project implementation

Programme level

In March 2009, the Ministry of Health, Welfare and Sports and the Ministry of the Interior asked ZonMw to develop a national implementation programme for the period 2009–2012. National-level goals of this implementation programme were as follows.

- Promoting quality and (cost) effective implementation structures to deploy district nurses at district level, especially in the problem districts.
- Increasing and improving the district nurse function at district level, contributing to: a more integrated community-based approach; cooperation between relevant care organisations and

parties; and reaching citizens with appropriate care services;
- Gaining insight concerning how the healthcare gap in problem districts can be solved through the district nurse.
- Ensuring to embed the insights and results gained from the programme into the district nurse function.

Project level

ZonMw installed a commission to judge and accept the project proposals and to follow the progress of the implementation. The commission judged the project proposals on the basis of relevance, quality, and on programme-related criteria. In principle, project proposals were accepted for the entire implementation period (2009–2012), provided that after a year the projects demonstrated prospects of success in terms of relevant targets. On 1 January 2012, 96 projects were running in districts in some 50 municipalities (of which 40 were problem districts). At the end of 2012, this had risen to 102 projects.

Within each approved project, a project manager is appointed. The project manager is responsible for the first contact with the cooperation partners and the recruitment of district nurses and plays a key role in the institutional embedding of the district nurse function.

Monitoring and evaluation

The programme commission of ZonMw monitors the progress of the individual projects through progress reports and final reports from the project managers. At the programme level, the commission did a midterm review in the spring of 2011 (see below) and will carry out an end evaluation. For these evaluations, and working in close consultation with the Ministry of Health, Welfare and Sports and the Ministry of the Interior, ZonMw formulated testable performance indicators (based on the programme targets and the programme-related criteria mentioned above).

Contextual factors

In all, the Dutch social and political climate for community-based care in general and the district nurse function in particular is fairly favourable. Traditionally, in the Netherlands the share of community-based care in total care is relatively high. Cost reduction policies of the former and present cabinet are increasing the level of community care (extramuralisering) and place more responsibility at community level (zorg in de buurt). Another rationale for increasing the level of community-based care is increasing patients' ability to live and do things independently for as long as possible (zelfredzaamheid). Legislation related to financial compensation in this field has been changed in favour of community-based care. In the coming years, this trend for more community-based care will continue. Within the policies concerning community-based care of the present Dutch cabinet , district nurses are one of the spearheads.

Outcomes and results

Type and number of jobs created

During the midterm review of Visible Link in the spring of 2011, 95 projects were running in districts in 50 municipalities (of which 40 were problem districts). At that time, the projects had recruited 250 district nurses of higher vocational training level (70%), 75 district nurses of intermediate vocational training level (21%) and about 30 employees from other disciplines, such as social workers (9%). Besides jobs for district nurses, jobs for project managers were also created. Given that during the midterm review not all the projects had finished the recruitment and selection phase yet, the final number of extra district nurses (and other employees) within the Visible Link initiative will certainly be higher.

The midterm review also shows that in the framework of the programme, several initiatives aimed at upgrading district nurses at intermediate vocational education level 4 to higher vocational training had been taken. Furthermore, some schools for higher vocational training focused their recruitment especially on district nurse students (ZonMw, 2011).

Other relevant outcomes

Reach: In the spring of 2011, the 95 projects reached more than 9,000 individual clients. This number was expected to increase substantially in the second half of the programme when the projects would be fully operational. Residents also appeared to find their own way to the district nurse. In agreement with the goal of the programme, the clients reached are mainly vulnerable citizens. The district nurses also reached people who had not yet received help.

Method of working: The midterm review shows that district nurses are spending more and more time with clients. On average, they spend 42% of their time on direct client-related activities, 27% on district-related activities (such as group information, multidisciplinary consultation or coordination) and 21% on project-related activities (such as team consultation and meetings).

When with clients, the district nurses carry out the following duties:

- stocktaking of the patient's needs and the care demand;
- giving information and advice;
- connecting the client to the right help and authorities or organisations;
- coordinating care workers and authorities or organisations;
- offering medical care and practical support.

As a basic structure, generally a care plan system is being used. This shows the broad and connective function of the district nurse. Activating clients to promote self-management in the field of care is a crucial duty, as is directing attention to preventative care at the individual and the group level.

The midterm review underlines the 'spider in the web' function of the district nurse between housing, (preventative) healthcare and welfare. The most intensive contacts are with the care side (home-care organisation, family doctor and health centre), followed by welfare. In about three-quarters of the projects, there is also contact with the housing corporation.

Main results

According to the midterm review, the added value of district nurses is first and foremost the integral approach. District nurses working within the Visible Link framework are (or at least can be) generalists who can consider clients' needs. In addition, they can use their freedom from rules to deploy suitable care. Furthermore, district nurses tend to ease the burden on general practitioners by undertaking care that the doctors do not have enough time for. Other partners, such as the housing corporation, benefit from the observing role the district nurses can play behind their clients' closed doors.

Secondly, district nurses contribute to concrete solutions for clients. District nurses offer appropriate and tailored solutions for clients and contribute to a better organisation of necessary care.

Thirdly, the deployment of district nurses leads to substantial cost reductions. Additional research by BMC confirms that it appears to lead to qualitatively better care as well as prevention and more efficient use of care (BMC, 2011, 2012).

Lessons learnt

Success and fail factors

An important success factor for the Visible Links projects is the favourable social and political climate in the Netherlands for community-based care in general and the district nurse function in particular. Furthermore, at the start of the projects, much attention is paid to obtaining a broad basis in the organisations concerned, at managerial level as well as implementing level. The parties involved regard the efforts of the district nurses in this respect as positive.

On the other hand, there have also been some negative factors, such as 'island formation', overlap and fragmentation in the care supply. In addition, in some projects it has been difficult to involve some of the general practitioners. Furthermore, the limited availability of trained district nurses in some project regions made recruitment more difficult. As mentioned above, in some cases projects tried to solve this problem by upgrading lower-qualified care workers. In other cases, employees from other disciplines were recruited (ZonMw, 2011).

Sustainability and transferability

The Visible Link programme as such stopped at the end of 2012. An important question is how to secure the structural embedding of the successful approach in the organisations involved and also how to transfer the approach to other contexts.

Regarding sustainability, the midterm review points to some problems to be addressed. Firstly, the function of the district nurse requires a certain freedom from rules in deciding, for instance, on the amount and type of care for patients. At the moment, this is the responsibility of the CIZ (see Chapter 1). Secondly, to secure the coordinating activities of the project managers, there must be structural funding for project management.

However, the future looks hopeful. Due to the programme's promising results so far, the former Ministers of Health, Welfare and Sports and of the Interior decided to make €10 million available annually for projects relating to district nurses (through the Municipality Fund). Additionally, the Rutte II cabinet has agreed to invest in extra district nurses from 2015, with an amount running to at least €250 million in 2017. Related to this is the development of a new, specific professional profile for the district nurse function (Expertisegebied wijkverpleegkundige) by the V&VN (the Dutch professional association of nurses).

Visible Link has already proven the transferability of the approach in the Netherlands. It started in a number of districts and expanded successfully to others over the years.

The Visible Link projects are mainly aimed at problem districts, giving the advantage of clearly demarcating the deployment of district nurses. In the post-programme period, the choice is between transferring the district nurse function to all districts in the Netherlands or to focus on districts whose inhabitants generally have poor health levels.

Conclusions

This case study concerned the Visible Link programme, which deployed 250 extra skilled district nurses, especially in problem districts, to provide home care by connecting aid organisations in the fields of housing, (preventative) healthcare and welfare at the district level.

So far, the implementation of the programme has been successful. The quantitative targets have been reached. The approach chosen for this programme also appears to have been successful in terms of health and well-being gains, improvement of cooperation between relevant parties at district level, and labour and cost reductions. Finally, the chosen approach contributes to the attractiveness of the job of district nurse and therefore to the possibilities for the recruitment and retention of care workers.

Visible Link finished at the end of 2012. Now the aim is to structurally embed the successful results of the programme and to transfer the approach to other contexts. The Dutch cabinet annually invests in extra district nurses and a new professional profile for district nurses has been developed. Therefore, the expectation is that district nurse initiatives will continue in the Netherlands.

Case study 3: Netherlands Neighbourhood Care

Description of the initiative

This case study focuses on the self-steering district teams of the Dutch home-care organisation Netherlands Neighbourhood Care (Buurtzorg Nederland). Netherlands Neighbourhood Care developed a new concept for nursing and care at home in which small self-steering district teams of skilled care workers have full responsibility for the nursing and care of clients at home.[6]

Netherlands Neighbourhood Care is a national non-profit organisation. It is a bottom-up, private initiative. It started in 2006 and now constitutes 470 self-steering district teams of nurses and orderlies, active all over the country.

Overall objectives

District nurses and orderlies can increase the potential of solutions by supporting the volunteer aid and by familiarising the clients with the formal health and social care system. When necessary, they provide the nursing and care at home themselves. To adequately fulfil this role, the teams of district nurses and orderlies have full responsibility for the care of patients at home. To do this, Netherlands Neighbourhood Care developed the concept of self-steering district teams of healthcare professionals. These local teams are supported and coordinated by a simple, 'lean and mean' national organisation. Netherlands Neighbourhood Care believes this approach contributes to the quality and efficiency of home care on the one hand and the attractiveness of the job of district nurse or orderly on the other.

Definition of the problem

Policy background

The non-profit Netherlands Neighbourhood Care Foundation is a bottom-up, private initiative. The Dutch central and civil authorities were not involved in the establishment of Netherlands Neighbourhood Care, but the Dutch cabinet actively promotes its approach (see Ministry of Health, Welfare and Sport, 2011a).

Role of the social partners

Though the 'founding father' of this organisation, originally a nurse himself, has partial roots in the Dutch professional association of district nurses, the social partners did not play a direct role in the creation of Netherlands Neighbourhood Care.

Issue at stake

According to Netherlands Neighbourhood Care, the Dutch home-care system has much room for improvement: there is not enough time or attention given to clients, inefficient administrative and care processes and a poor profession image among potential employees.

[6] Henceforth, when using the term 'care', this encompasses any care or nursing required by the patient.

Approach and implementation

Overall approach

A self-steering team is as a relatively permanent group of employees in an organisation who are collectively responsible for the total service provision to clients. This concept is based on the following three founding principles.

- Collective responsibility: the team is at the centre, not the individuals.
- Self-steering: the team has the capacity to steer the service in question.
- Result orientation: the team's responsibility is expressed in terms of results rather than tasks.

Based on these principles, Netherlands Neighbourhood Care developed a new concept for nursing and care at home in which small self-steering teams of skilled district nurses and orderlies have full responsibility for the care of clients at home. All tasks lie within the self-steering team. The teams operate at district level and are supported by a 'lean and mean' national organisation by using modern ICT applications, which pushes down the administrative burden and costs.

Aim of the initiative

By giving small self-steering district teams of highly skilled district nurses and orderlies full responsibility for nursing and care at home, better use is made of the employees' problem-solving abilities and professionalism. Besides improving the quality of care, this approach also contributes to reducing shortages in care personnel. Theoretically, positive labour market effects are:

- more efficiency (less labour demand, lower labour costs): less overhead personnel are needed and the same amount of care can be provided by fewer people (or more care by the same amount of personnel);
- more inflow: as a rule, people prefer a system with less bureaucracy and more responsibility;
- less outflow: if employees are more satisfied with the work, there will be less urge to leave the organisation (or the branch as a whole).

Recruitment versus retention

The approach of the self-steering teams of Netherlands Neighbourhood Care is aimed at the recruitment as well as retention of district nurses and orderlies.

Specific target groups

The recruitment of nurses and orderlies does not aim at specific target groups.

Formal versus non-formal employment

There is no aim for a transfer of non-formal to formal employment.

Project implementation

Programme level: National-level organisation strategy

The supporting organisation at the national level is of a professional calibre, but is simple too. Netherlands Neighbourhood Care deploys its formula in three ways:

- cooperation with other care organisations: Netherlands Neighbourhood Care works with organisations in the field of nursing homes, homes for the elderly and home care wishing to deploy the Netherlands Neighbourhood Care formula to improve or extend their home-care activities;[7]
- Netherlands Neighbourhood Care Foundation: if cooperation agreements with these organisations are not possible, it sets up teams itself;[8]
- cooperation with 'like-minded organisations': Netherlands Neighbourhood Care works together with parties that support their philosophy and can contribute to the professional development of care provision at home.

Project level: Self-steering district teams

Each team consists of 10–15 care professionals at intermediate or higher vocational education level.[9] Though the recruitment of nurses and orderlies does not aim at specific target groups, the district orderlies employed are at intermediate vocational education level 3 and the district nurses are at intermediate vocational education level 4 or higher. The team works closely with the local care network (general practitioners, pharmacies, nursing and retirement homes, home-care shops (thuiszorgwinkels), hospitals, and so on). The team is accessible at all times day and night, not only for clients and their acquaintances, but also for doctors and the local hospital. The team works with the client with the aim of making the client independent of care as soon as possible. Where independent living is not feasible, the team and client search together for the most helpful and pleasant solution for that client's needs.

Monitoring and evaluation

Netherlands Neighbourhood Care provides for nursing and care according to professional standards. These standards are evidence-based and monitored. Sometimes, Netherlands Neighbourhood Care is the subject of evaluation research by third parties (see below).

Contextual factors

The main characteristics of Netherlands Neighbourhood Care are the community-based and self-steering approach. In the Netherlands, there is an ongoing trend towards more community-based and less institutionalised care. District nurses are the spearhead to the current Dutch cabinet's community care policies and the government holds up Netherlands Neighbourhood Care as an example.

Currently, there is an increasing tendency in Dutch policies to combat bureaucracy. On 1 January 2012 the Dutch Ministry of Health, Welfare and Sports started the experiment Regelarme instellingen (Institutions with low pressure of rules). Furthermore, the Minister of Health, Welfare and Sports recently declared her intention to cut waste in care as a policy spearhead for the current cabinet. Waste includes throwing away unused medicines or dressing material, unnecessary care activities and redundant managerial layers. This same mentality and approach are apparent in the flat organisational structure of Netherlands Neighbourhood Care.

In all, the current policy tendencies in the Netherlands provide good conditions for the approach of the self-steering district teams of Netherlands Neighbourhood Care.

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[7] Apart from organisations in the field of nursing homes, homes for the elderly and home care, groups of general practitioners can also purchase the Netherlands Neighbourhood Care formula.

[8] Employees of these teams are in the pay of the Buurtzorg Nederland Foundation.

[9] Important competences asked for: independent and enterprising; being able to cooperate with other professionals; and being able to find a good balance between professional standards and the individual situation or needs of the client.

Outcomes and results

Type and numbers of jobs created

In 2012 there were 470 self-steering district teams compared to 360 in 2011, and 5,500 employees compared to 3,700 in 2011. The number of employees recruited yearly amounts to 1,200. The scope of the teams is noteworthy, as they are spread all over the country, with each team offering home care in a district of approximately 10,000 inhabitants.

Main results

According to an evaluation by NIVEL, clients have a lot of confidence in the skill of the Netherlands Neighbourhood Care professionals and highly appreciate their flexible attitude. Compared to other Dutch home-care organisations, Netherlands Neighbourhood Care clients awarded the highest scores on the quality of care given. Clients especially appreciated the accessibility of the team by phone, the employees' professionalism and the safety of the care. Meanwhile, Netherlands Neighbourhood Care employees report being able to offer optimal care and experiencing a strong team spirit as advantages. General practitioners are also highly satisfied with the accessibility and professionalism of the employees of Netherlands Neighbourhood Care. Employees and doctors alike label the method of working as familiar and reliable and have trust in each other (NIVEL, 2008, 2009).

According to a more recent study by Vermeer and Wenting (2012), self-steering teams economically and socially outperform traditional forms of home care. Self-steering teams are cheaper because of lower overhead costs. For the employees concerned, the approach means more variation in activities, the development of new skills, more challenges and higher levels of responsibility. As a result, the quality and enjoyment of work increase. Higher satisfaction with work in turn leads to more commitment from employees.

Another recent study, Beste Werkgeversonderzoek (Best Employer Survey) demonstrates this employee satisfaction. As in 2011, Netherlands Neighbourhood Care won the category of employers with 1,000 employees or more, surpassing reputable employers such as KLM, Ahold, Nationale Nederlanden and Randstad.[10]

Lessons learnt

Success and fail factors

First of all, as mentioned above, the social and political climate for the Netherlands Neighbourhood Care approach is favourable. Secondly, potential employees and clients are both attracted to the concept, as detailed in the previous section. Thirdly, Netherlands Neighbourhood Care seems to adequately implement the concept of the self-steering district teams. Based on their experiences with the teams, Vermeer and Wenting (2012) formulated the following conditions for success regarding self-steering teams:

- the team works within clear frames, agreed upon with the management. Within these frames, the self-steering team has the authority to make its own decisions;
- a team is well-balanced (good balance between full-time and part-time employees, between orderlies and nurses and between competencies);
- within the team, there is agreement on the division of tasks. The self-steering team regularly holds an adequately functioning meeting to discuss work. This meeting is solution oriented. Decisions are taken according to the consensus principle;
- besides their individual responsibilities, members of the self-steering team feel jointly

[10] www.effectory.nl/medewerkersonderzoek/beste-werkgevers-awards

responsible for the organisational tasks and the group results;
- the members of the self-steering team get on well together and feel comfortable in the team;
- the self-steering team has good results (Vermeer and Wenting, 2012; In voor zorg, 2012).

There are also some potential fail factors:

- participating in a self-steering team requires certain personal characteristics, such as self-support, flexibility, empathy, the ability to handle criticism, and so on. Not all care workers can meet these needs;
- too much commitment from team members can lead to overburdening, especially in the pioneering phase of a self-steering district team. This can be prevented by making clear agreements concerning who is accessible at what time and by using the intranet to coordinate schedules. In this respect, an open attitude and communication are also important (Vermeer and Wenting, 2012).

Sustainability and transferability

The Netherlands Neighbourhood Care organisation has already proven to be sustainable. Established in 2006, there are already 470 teams and the number is still growing.

The approach has also proven to be transferable to other contexts. Netherlands Neighbourhood Care supports the creation of teams within other organisations. The Ministry of Health and Welfare is also in favour of mainstreaming the approach. Netherlands Neighbourhood Care has also expanded its activities to other branches and care organisations. Buurtzorg Plus, for instance, was established in 2010 and involves Buurtzorg teams collaborating with physiotherapists and occupational therapists specialising in home care. Buurtdiensten also started in 2010 and focuses more on an integrated form of welfare work, long-term and domestic care. In 2012, Buurtzorg Jong emerged and is active in youth welfare work. These smaller, multidisciplinary district teams contain youth nurses, welfare workers and education specialists. Finally, BuurtzorgT is an initiative that cooperates with MoleMann Mental Health and provides mental care, support and guidance at home through smaller self-steering teams that each have their own psychiatrist.

The Netherlands Neighbourhood Care approach is also transferable across national contexts. The first Buurtzorg team started in Sweden in December 2011. In addition, Belgium, Canada, China, England, Japan, Korea, Scotland, Switzerland and the US are also interested in the Buurtzorg formula (Zorgvisie, 2012).

Conclusions

At the centre of this case study is the concept of the self-steering district teams of Netherlands Neighbourhood Care. So far, the approach has proven to be successful on several fronts. Both clients and team employees enjoy the initiative. Clients enjoy the accessibility, flexibility and quality of care, while employees take pleasure in the working relationships they form, the increased responsibility and ultimate ability to provide better care. Labour productivity and the situation of current care services seem improved under this measure, which may in turn lead to the retention and possible recruitment of care workers.

The Buurtzorg approach has proven itself sustainable, having existed since 2006. The Buurtzorg formula has also turned out to be highly transferable to other organisations in the field of nursing and retirement homes and home care, as well as to groups of general practitioners, to other countries and to other health and social care branches.

Annex 2: List of organisations contacted

Actiz, Sectoral organisation for institutional and home care
PO Box 8258, 3503 RG Utrecht, the Netherlands

BTN, Sectoral organisation for home care
PO Box 4050, 4900 CB Oosterhout, the Netherlands

GGZ Netherlands, Sectoral organisation for care for psychically disabled people
PO Box 830, 3800 AV Amersfoort, the Netherlands

Ministry of Health Care, Welfare and Sport, directory MEVA
PO Box 20.350, 2500 EJ The Hague, the Netherlands

NPCF, National Platform for Patients and Care Consumers
PO Box 1539, 3527 GV Utrecht, the Netherlands

VGN, Sectoral organisation for the care of the disabled
PO Box 413, 3500 AK Utrecht, the Netherlands

V&VN, Organisation of caregivers
PO Box 8212 3503 RE Utrecht, the Netherlands

Neighbourhood Training Company

Calibris, Expertise centre for the care professions
PO Box 131, 3980 CC Bunnik, the Netherlands

Visible Link

ZonMw
PO Box 93.245, 2509 AE The Hague, the Netherlands

Netherlands Neighbourhood Care

Buurtzorg Nederland
PO Box 69, 7600 AB Almelo, the Netherlands

Douwe Grijpstra, Peter de Klaver, Jacqueline Snijders, Amber de Graaf and Paul Vroonhof, Panteia Zoetermeer Research Centre

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