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Support of working informal caregivers in the Netherlands and in Germany

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Abstract

The division of responsibilities and organizational structures in the field of long-term care is a subject of much discussion. This is made even more clear by the EU Work-Life Balance Directive of June 2019. In view of the rising pressure of combining work and care, it is important to enable and facilitate the working informal caregiver. In this paper an attempt is made to gain more insight into this issue. We identified the opportunities and risks of an informalization of care and studied how persons in the Netherlands and Germany are being supported to combine the different roles and tasks. The comparison shows that informal care is not only a responsibility of the individual and/or the employer but that the government should play a role in facilitating and enabling working informal caregivers. This can also be defended on efficiency arguments. It is not possible to take out an insurance against the provision of informal care on the private market. Furthermore, providing informal care has negative external effects related to a reduction of labour market participation and the ensuing costs for society.

1. Introduction

In his first 'Speech from the Throne' the Dutch King Willem-Alexander observed that the classic welfare state is slowly turning into a participation society. Some said this observation signified the end of the post-war welfare state (Putters 2014, p. 8). Others stated that the introduction of the participation society essentially involves a different division of collective and individual responsibilities (Tonkens 2014). This discussion on the division of tasks and responsibilities between the government, the citizens and the market is not a new one. As of the eighties the need for this reassessment has been felt, given the rising costs of and collective expenses for social security and care. The need for a modernisation of social security also plays a role. The classic welfare state, established and shaped in the period after the Second World War, does not meet the present wishes and needs of citizens anymore. It seems desirable to have more opportunities to control one's own life and make one's own choices. One of the areas that shows a lively discussion on a different division of the responsibilities and organisational structures is long-term care. In recent years significant changes have been introduced here. The new Dutch Social Support Act (*Wet maatschappelijke ondersteuning, Wmo 2015*) has come into effect, and as of January 1, 2015, the Dutch Long-Term Care Act (*Wet langdurige zorg, Wlz*) has been in force.

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This legislation has introduced new principles and starting points with a focus on citizens' own responsibility and self-reliance. Simultaneously citizens are expected to take more care of one another. They are expected to find assistance, support or care in their own circle first, before turning to the state for help. The underlying idea is that parts of the care, which are currently being performed by professionals and for payment, could in the future be performed more on an informal basis and in kind. The informalization of care is deemed an important solution for the system's affordability and the sustainability of long-term care (OECD 2011, p. 177).

In addition, demographic and societal developments will lead to an increased need of care, as a result of which paid work will increasingly be or have to be combined with e.g., the care for children and loved ones (Broek et al. 2016, p. 15). This presents opportunities, but it also entails risks. From the perspective of combining tasks and roles one may expect to see a trade-off between the time spent on working on the one hand and on care on the other hand. There will be an increased chance of such a trade-off, as in the field of work and income the government will also continue to aim for an increased labour market participation.

In view of the rising pressure of combining ever more tasks, it is important to enable and facilitate the working informal caregiver. This has also been recognised at EU level where in 2019 a new EU directive on work-life balance for parents and carers entered into force.⁴ It is by no means certain whether, given the changing context, the current enablement in the Netherlands is still optimally organised. In this paper an attempt is made to gain more insight into this issue by identifying the opportunities and risks of an informalization of care and by studying how persons are being enabled and facilitated to combine the different roles and tasks. A study was made of the situation in the Netherlands as well as of the support of the working informal caregiver in Germany. The decision to make a comparison with the neighbouring country Germany was motivated by the fact that here the family (together with the government) is largely responsible for the long-term care. Unlike the Netherlands, Germany recognises a mutual familial solidarity, which is laid down by law (Verbeek-Oudijk et al. 2014, p. 42). The reforms implemented here in recent years have focused on promoting labour market participation and on maintaining the providing of informal care. In doing so, other choices were made than in the Netherlands. This paper shows which choices were made and poses the question: what can we learn from this comparison between two countries that differ from an institutional point of view but face the same challenges? The developments at EU level underline the relevance of dissemination of good practices at national level and thorough analysis on work-life balance issues.

The paper is organised as follows. In section 2 we give a concise overview of the various definitions used in the literature to describe the present offer of informal care (care provided by a person from one's social network (*mantelzorg*) and care provided by volunteers). Section 3 studies which developments affect the need of care and the availability of informal caregivers in the Netherlands and in Germany. Section 4 outlines the opportunities and

⁴ Directive (EU) 2019/1158 of the European Parliament and of the Council of 29 June 2019 on work-life balance for parents and carers and repealing Council Directive 2010/18/EU, OJL 188, 12.7.2019. Article 6 introduces a new right of carers' leave of five working days per year per employee and article 9 extends and strengthens the right to request flexible working arrangements to carers.

challenges that may result from the informalization of care. Section 5 summarizes the facilitation of informal care in the Netherlands. Section 6 outlines the legal framework of informal care in Germany, the changes that have taken place there and compares the German regulations with those in the Netherlands. In section 7 we dwell on the question: what can we learn from Germany and what are the opportunities and challenges for the Netherlands in this regard?

2. Informal care: definition and characteristics

As regards support to family and acquaintances in the literature various terms are used interchangeably. Some examples hereof are: *mantelzorg* (care provided by a person from one's social network), volunteer work, informal help or informal care. Although there is some overlap between these terms, there are definitely also differences. The Dutch term '*mantelzorg*', introduced by Hattinga-Verschure (1987), refers to 'all care received within a small social network and provided to one another based on naturalness and the willingness to reciprocate' (Hattinga Verschure 1987, p. 92). Essential features hereof are the short lines between the persons involved and the fact that an individual may be both a caregiver and a care receiver.

Mantelzorg is also described as care, which is provided by one or more members in the direct environment of the person in need of help, who do not act in the quality of care professional. The provision of care follows directly from the social relationship.⁵ This characteristic distinguishes *mantelzorg* from volunteer work. Volunteer work in the care sector relates to 'volunteers who, unpaid and voluntarily, perform activities in an organised context for others who need care and support and with whom -at least at the start- they have no personal relation (Boer et al. 2013, p. 10). Another distinction is that *mantelzorg* (often) 'happens to' persons, when someone in their direct environment becomes subject to restrictions, while volunteers choose to care.

Mantelzorg and volunteer work in the care sector are jointly referred to as informal care. Informal care therefore refers to care and support provided by informal caregivers, relatives, neighbours, friends and volunteers to persons in need of care and support, who do not claim payment of a salary for this. Informal care is thus the counterpart of professional care.

Estimates are that in the Netherlands over four million persons provide informal care. The intensity and duration of informal care vary: approximately 750,000 persons provide help for more than three months and more than eight hours per week. On average informal caregivers give care seven hours a week during an average of five years. The involvement with informal care depends on among other things age, gender, education, and work. In the Netherlands women provide care more often than men and more than half of all informal caregivers is in the 45 - 64 age range (Boer et al. 2019, pp 10-11). Between 2004 and 2014 the percentage of working persons providing informal care rose significantly (from 13 to 19 per cent) and will, in view of several developments in society, most probably continue to rise in the future (Josten et al. 2015, p. 422.).

⁵ This definition of *mantelzorg* was extracted from the Dutch National Advisory Council for Public Health (*Nationale Raad voor Volksgezondheid*).

Studies on informal care in Germany show that approx. 4.7 million persons (6.9 per cent of all adults) regularly provide care for more than seven hours a week to loved ones in need of care, i.e. loved ones who are entitled to a benefit in money or in kind under the German Long-Term Care Insurance (*Pflegeversicherung*) (Wetzstein et al. 2015, p. 1). The average weekly number of hours depends on the definition used and ranges from 13.3 to 49.3 hours. Almost two thirds of them are women. Most caregivers are close relatives (approx. 50 per cent provides care to their own parents and 18 per cent to their partner) and around one in ten caregivers is a friend, an acquaintance or a neighbour of the person in need of care. Approximately half of the 4.7 million caregivers (around 2.37 million) belongs to the potential working population and out of these 2.37 million, approximately 1.9 million persons actually participate in the labour market (Unabhängiger Beirat für die Vereinbarkeit von Pflege und Beruf 2019, p. 15). Due to the use of different definitions these numbers cannot be compared to the Dutch numbers.

3. Trends in society, the demand for care and the supply of informal care

Similar trends in the Netherlands and in Germany affect the demand for and the supply of informal care.

First the demographic developments can be mentioned: both countries have an ageing population combined with a dropping average birth rate. The Netherlands Institute for Social Research (SCP) has calculated that the use of care in the Netherlands by the elderly living at home will increase till 2030 (by an average of 1.5% a year), in particular by those who require personal care, nursing and supervision, the heavier forms of care (Eggink et al. 2012, p. 11). The increasing reliance on care is to a large extent driven by technological developments; new possibilities create a new demand. It is estimated that in Germany the number of people needing care will increase from 3.4 million to over 5.9 million in the period between 2017 and 2050 (Unabhängiger Beirat für die Vereinbarkeit von Pflege und Beruf 2019, p. 12).

Another notable trend is that the increase of the healthy life expectancy (the number of years that people live in perceived good health) lags behind the increase of the total life expectancy, and that the life expectancy without chronic illnesses has even been decreasing (Brakel et al. 2020, p. 96). Both the Dutch and the Germans thus experience illness and chronic illnesses during a longer period of their lives leading to a more varied and intensive demand for care. Furthermore, the trend of individualisation leads to a change in the demand for care, among other things to an increasing need for autonomy and freedom to organise one's life according to one's own views (for example the wish to continue living independently longer).

The care offer differs in both countries. The Netherlands have long held on to a policy aimed at the 'defamilialization' of care activities, where long-term care was highly collectivized, and the state offered various services. This was based on a statutorily required national insurance, the Dutch General Law on Exceptional Medical Expenses (*AWBZ*), under which the risk of long-term and chronic care was ensured since 1968. In recent years this policy has come under pressure and has been changed. As a result of the new policy the elderly will have to continue to live at home longer and under the Long-Term Care Act (*Wlz*), the successor of the *AWBZ*, the threshold to qualify for a nursing home has been raised substantially.

Germany on the other hand traditionally has had a more familial system. Compared to the Netherlands the elderly and those in need of care stay at home longer, often cared for by their children or by others dear to them. Germany was quite late in recognising the care risk as an independent risk. They did so in 1995 when the statutorily required *Pflegeversicherung* (long-term care insurance), an insurance that is by and large comparable to the Dutch Long-Term Care Act (*Wlz*) was adopted. Unlike in the Netherlands however the insured care in Germany is meant to supplement the care given by relatives, neighbours, and other volunteers, and therefore the *Pflegeversicherung* only partially covers the costs. If for example a person in need of care (with a partner) has insufficient income or assets, the state will bear the costs. The state however does not bear the costs alone. In case there are children, the German Social Services may under certain conditions reclaim the costs from the children. For in Germany parents and their children are mutually obliged by law to contribute to living expenses.⁶ Informal care will be one of the major pillars in the societal care responsibility also in the future, all the more so as the 'familial' approach in the German care and welfare system also implies that a recourse to public funds comes into play only when the existing provisions are exhausted. These provisions comprise both the *Pflegeversicherung* and the care by relatives.⁷ Within this pillar the care responsibilities are steadily increasing as people continue to grow older, care becomes more expensive and social funds get drained (Seibl 2014, p. 1151). In recent years the provision of care by female migrants from the CEE countries, in particular from Poland, has risen significantly. If this development continues, it can be regarded as 'a third pillar' in home care, apart from the familial and the professional care (Lutz 2009, p. 43; ver.di 2014).

As regards the developments on the supply side of informal care, the increasing labour market participation of women deserves attention. More time for paid work in all probability means less time for care (Boer et al. 2019, p. 12). Broese van Groenou also points to the more complex family structures, the strongly increased numbers of both divorces and new types of relationships and families, which in all probability will affect the readiness to give care of the next generation of informal caregivers (in the 45-65 age range) adversely. Also, the actual possibilities are more limited. As households are smaller (at present over a third of households in the Netherlands consists of single-person households), there are less persons in a household to take care of each other. Furthermore, there is a higher degree of geographic dispersion in families than in earlier generations; parents and children more often live far apart, which limits the possibilities to provide certain types of informal care, such as personal care and household help (Broese van Groenou 2012, p. 16).

As a result of the aforementioned demographic developments and the increased number of single-person households the demand for care will thus most probably increase. Whether this demand can be met is unclear. It is

⁶ This form of solidarity is far-reaching. It may amount to several hundreds of euros a month, exists till death and for example also applies when the parent has rejected contact for years (*BGH*, 12.2.2014 - XII ZB 607/12). It can only be mitigated or lapse in exceptional situations, for example if the parent has neglected his or her own maintenance obligation towards the child. As of January 1, 2020, the boundary has been set at an annual income of €100,000. The children's income can only be used above this level (*Angehörigen-Entlastungsgesetz; § 94 Absatz 1a SGB XII*). Germany also has a maintenance obligation between relatives in the direct line. Theoretically this extends to grandparents or great-grandparents and grandchildren or great-grandchildren. Here however Social Services has no right of recourse with regard to the claim of the maintenance recipient to the maintenance debtor.

⁷ *§ 2 SGB XII* provides as follows: „Sozialhilfe erhält nicht, wer sich vor allem durch Einsatz seiner Arbeitskraft, seines Einkommens und seines Vermögens selbst helfen kann oder wer die erforderliche Leistung von anderen, insbesondere von Angehörigen oder von Trägern anderer Sozialleistungen, erhält“.

likely however that in both countries the number of persons combining tasks will increase, as a growing number of working persons will increasingly combine tasks. In the field of informal care there will be a shift from providing care as an exclusive activity to providing care in combination with paid work.

4. Opportunities and challenges of the informalization of care

Informal care is often seen as a burden and an obligation; however informal care also involves important values, particularly because of the individual attention and personal relation. Informal care is not only about activities such as eating, cleaning, or taking care of someone's finances. It is the emotional responsibility that is essential. It is all about caring for one another (Beneken Genaamd Kolmer 2011, p. 36).

Both in the Netherlands and in Germany the government recognises the importance of a flourishing civil society, in which citizens participate in volunteer work and can spare time for informal care.⁸ The aim is to strengthen social cohesion between the citizens. Apart from creating a pleasant living environment, this also has an economic value. For example, when citizens take care of their ill and disabled co-citizens to a larger extent, this may result in the latter staying at home longer and in a decreased need for residential and non-residential professional care.

In the Netherlands, the Explanatory Memorandum to the Dutch Long-Term Care Act refers to the increased involvement of society as one of the main motives to reform the long-term care system. The government also expects that increased self-reliance will result in a decreased use of collective services. This self-reliance encompasses various elements, such as the possibility to use one's own assets and the possibility to engage one's social network. In the literature however the nature of the relationship between informal care and professional care is disputed (Verbeek-Oudijk et al. 2013, p. 47). Some authors are of the opinion that, if informal care does not replace but mainly supplements professional care, the assumption that an increased reliance on informal care will lead to cost savings is not a realistic one. Informalization, if certain preconditions are observed, can very well stimulate certain new forms of care, such as care cooperations or initiatives by elderly persons to organise housing by themselves. Such initiatives may in the longer term lead to a quality improvement and a cost reduction.

An informalization entails both opportunities and risks. The main risk is that both goals, i.e. the promotion and/or preservation of the labour market participation and the care participation, are not achieved. On the one hand the effort to increase labour market participation may lead to pressure on the informal care supply, on the other hand the increased need of informal care, i.e., the demand for care time, may have a negative influence on the labour supply. Paid work and informal care thus compete with one another. It is not certain whether such tensions will

⁸ See for the Netherlands the developments in the field of the Dutch Social Support Act (*WMO 2015, Stb. 2014, 281*) prepared in Parliamentary Proceedings 33 841 and the Dutch Long-Term Care Act (*Wlz, Stb. 2014*), prepared in Parliamentary Proceedings 33 891 and for Germany the policy goals as included under the heading '4. *Zusammenhalt in der Gesellschaft*' in: The coalition agreement between CDU/CSU and SPD: '*Deutschlands Zukunft gestalten*', 2013 and under the heading '4. *Gesundheit und Pflege*' in: The coalition agreement between CDU/CSU and SPD: '*Ein neuer Aufbruch für Europa. Eine neue Dynamik für Deutschland. Ein neuer Zusammenhalt für unser Land*', 2018.

occur in practice. Empirical studies both in the Netherlands and in Germany on the relationship between labour market participation and informal care show a varying picture.

In the Netherlands, a study by the Netherlands Institute for Social Research (*SCP*) shows that working persons who provided intensive informal care (over four hours a week) and worked relatively long hours, had increasingly reduced their employment participation. Seventeen per cent of them had switched to working at least four hours less a week; seven percent had quit working altogether. Long-term sickness absences of two consecutive weeks or more in a calendar year had also increased strongly (Josten and De Boer 2015, p. 9). Studies of the Netherlands Bureau for Economic Policy Analysis (*CPB*) also indicate that informal care may have a negative influence on labour market activities, as regards both participation and the number of hours and salary, in particular with respect to intensive informal care (Ewijk et al. 2013, p. 32).

In Germany, it is also difficult to combine care and a full-time or a substantial part-time job. A mere quarter of the informal caregivers works full-time and approx. 30 per cent has reduced the extent of their employment due to care activities and works mostly in a small part-time job. 44 Per cent of the informal caregivers in the working age population does not perform any paid work at all (Rothgang et al. 2015, p. 193; Hielscher et al. 2017, pp 91-92).

The informalization of care poses challenges relating to the labour supply, as well as to the accessibility and the quality of informal care. Several persons in need of help have no access to informal care, as they are single or only have a very small network they can rely on.

The possible overburdening of the informal caregivers also constitutes a risk. Most people do not choose to give informal care; it happens to them and the burden of it increases in the course of time. In this context the term 'informal care trap' (*mantelzorgval/mantelzorgklem*) is being used. Studies in both Germany and the Netherlands show that this 'trap' is real.

More than half of the 1.9 million people in Germany who combine informal care with paid work consider this combination to be a hard one (Bundesministerium für Familie, Senioren, Frauen und Jugend 2014, p. 7). A study by the German Trade Union Confederation (*DGB*) shows that 71% of all employees with care responsibilities are permanently under time pressure (DGB 2018, pp 21 and 25). As a result, informal caregivers have less time for themselves, which especially for caregivers aged 45 and over has negative consequences for their mental well-being (among other things depressions). According to this study the risks of overburdening and of social isolation are very real.

In the Netherlands a substantial part of the informal caregivers also feels heavily burdened (Klerk et al. 2017, pp 11-12). The providing of informal care increases chances of mental health problems, particularly when intensive informal care is involved. Caring for a person with dementia is hard, especially when the informal caregiver and the patient live together. In the 'Dementia Monitor Informal Care' almost four in ten informal caregivers (39%) indicate to feel quite heavily burdened by this care and 13% feels very heavily burdened or overburdened (Heide et al. 2018, p. 17). Overburdening entails risks for both the informal caregivers and the receivers of care. As a result of

overburdening and illness informal caregivers may be absent through illness (and/or temporarily stop with paid work) or may not be able to provide good care anymore. In grave situations this may even lead to care going 'off the rails'. In case of overburdening informal care may thus entail not only benefits but also expenses for society.

The financial consequences of providing informal care may also constitute a risk factor. These include the additional expenses incurred by informal caregivers or the lower income they have by spending part of their time on care. As appears from a German study, 44% of the main informal caregivers has a monthly income not exceeding €1,000 (Unabhängiger Beirat für die Vereinbarkeit von Pflege und Beruf 2019, p. 24). Caring for a sick family member may result in a loss amounting to almost one third of one's income, if the informal caregiver feels compelled to work less hours. In the situations under consideration the financial consequences are severest for informal caregivers who are trapped between a job, a family and the care for parents. When they feel compelled to work less hours or even quit working, this has huge financial consequences (Parliamentary Proceedings 30 169, no. 38).

Finally, it can be pointed out that a 'familial system' where the primary care responsibility rests with loved ones, relatives or friends involves a certain 'gender sensitiveness'. As women tend to provide informal care (slightly) more often than men, and as they also participate more often in volunteer work with a caring character, chances are that the care which the participation society expects from its citizens will mainly fall on the shoulders of women, more specifically older women. This may have consequences for their labour market participation or for the care for their own families. Furthermore, it is then also mainly women who are faced with the financial consequences of combining work and informal care.

5. The enabling and facilitating of informal care in the Netherlands

In the Netherlands, the support of employees providing informal care comprises a wide range of tools offered by the government, social partners, work organisations and the market. This section focuses on the statutory framework and informal care. Three dimensions are distinguished here: time, money, and services. It should be noted that certain instruments will explicitly relate to the support of informal caregivers who apart from giving informal care also perform paid work (for example the statutory care leaves), while other instruments are implemented in a more general way, in support of all informal caregivers whether or not they perform paid work.

Time and money

In the Netherlands, the Work and Care Act (*Wet Arbeid en Zorg, Wazo*) is the main Act that regulates types of leaves for employees with care responsibilities. In this Act employees giving informal care are granted time for care in the form of a leave, whether on full pay or not. It is important to point out that the leave regulations may serve different purposes. Some regulations only grant a right to time (with a guaranteed return to the 'old' job), while other regulations also grant a right to money, thus limiting or compensating for the loss of income caused by working less hours temporarily or by not working at all.

The Dutch Work and Care Act came into effect on December 1, 2011 (*Stb* 2001, 567) and was amended several times since then. The most recent amendment relates to the introduction of the 'Leave and Working Hours Arrangements

Modernization Act' (*Modernisering regelingen voor verlof en arbeidstijden*) (Stb 2015, 245). According to the relevant Explanatory Memorandum this Act essentially eliminates obstacles in the Work and Care Act and in the Working Hours Adjustment Act (Waa), so that the provisions contained herein can be applied in a more flexible way (Parliamentary Proceedings 32 855, no. 3). In other words, the Modernization Act makes some leaves under the Work and Care Act (*Wazo*) more flexible. The Work and Care Act regulates leave forms that are of particular relevance to the performing of informal care. These are the emergency leave (*calamiteitenverlof*), the short-term care leave (*kortdurend zorgverlof*) and the long-term care leave (*langdurend zorgverlof*).⁹

The right to an emergency leave exists for short-term, special situations in which the employee is unable to work. The emergency leave provides a solution for unforeseen circumstances, situations that do not permit any delay. Some examples in the informal care sphere are caring for a sick loved one on the first day of sickness or accompanying a loved one on a visit to a doctor or a hospital. The parties entitled to this leave are employees. No objective access conditions apply, apart from the requirement that an emergency situation must exist; both the care and the accompaniment must be necessary. The length of the emergency leave is limited, ranging from a couple of hours to a maximum of several days. Essential is the time required to take emergency measures. The Act refers to a 'period to be determined equitably'. The employer is under an obligation to continue paying wages. However, it is possible to make other arrangements. This implies that the arrangements may offer more or less than the statutory regulations.¹⁰

Care leaves can be distinguished into a short-term care leave not exceeding two weeks and a long-term care leave not exceeding six weeks in each period of twelve months. The short-term care leave offers the possibility to care for a sick loved one. The long-term care leave is possible for persons with a life-threatening illness as well as for persons who are sick or in need of help. For both types of leaves it is required that care by the employee is necessary. During the short-term care leave the employee is entitled to 70 per cent of his/her salary (maximum daily pay) which must amount to at least the statutory minimum pay or the statutory minimum youth wage. The long-term care leave is unpaid. Collective labour agreements may contain different arrangements for both types of leaves. Furthermore, the right to both the short-term and the long-term care leave is conditional, i.e. the leave may be refused due to serious business reasons that reasonably prevail over the interests of the employee.

Under the Leave and Working Hours Arrangements Modernization Act the category of persons entitled to an emergency leave, a short-term or a long-term care leave was extended and made uniform. Besides for relatives in the first degree, these forms of leave can now also be taken for relatives in the second degree (a brother or sister, grandparents, and grandchildren), other household members than children or a partner (a live-in aunt) and others with whom the employee has a social relationship (a friend, a neighbour). The government deemed this necessary as, due to the increased mobility and the rising female labour market participation, there is a growing group who

⁹ Burri & Heeger-Hertter 2020, pp 158-160.

¹⁰ With this so-called 'two thirds' or 'five eighths' compulsory law the legislator wanted to stress in the Work and Care Act that statutory law is standard setting, i.e. it is the point of departure. Employees therefore have a right, unless other arrangements were made in a collective agreement or between the employer and the works council or the employee's representatives. See Parliamentary Proceedings (*Kamerstukken II 2001-2002, 28 467, no.3, pp. 5 and 12*).

cannot rely on direct relatives or household members for their necessary care (Parliamentary Proceedings, 32 855, no. 17).

Despite the existence of leave options, it turns out that little use is made of the leave arrangements; the long-term care leave in particular is not taken at all or hardly ever taken. A mere two per cent of the employees takes a long-term care leave. Possible explanations for this are: a lack of awareness of the arrangement, the organisational culture, or the existence of informal and tailor-made arrangements. Another reason for the limited use may be its statutory unpaid character, more so as collective labour agreements also contain relatively few arrangements on continued payment of wages in case of a long-term care leave.

A study of collective labour agreements by the Dutch Ministry of Social Affairs and Employment (SZW) shows that the majority of arrangements on the long-term care leave are in line with the statutory regulations. In nine in ten collective labour agreements in the care sector wages continue to be paid in whole or in part, whereas this is the case only in some collective labour agreements in the public and private sectors. Continued payments range from ten per cent up to ninety per cent (Ministerie SZW 2018, sect. 4.2.6). Studies on collective labour agreements by the Netherlands General Employer's Association (AWVN) show an increase in the number of arrangements on the support of employees who provide informal care. These are often procedural arrangements (i.e., on the recognition of informal care, on making it discussible and on drawing attention to it) (SER 2016, p. 96).

Besides the different leave arrangements flexible working may also contribute to the combination of work and informal care. As of January 1, 2016 the Dutch Flexible Working Act (*Wet flexibel werken, Wfa*) has provided the statutory framework. The Flexible Working Act, which replaced the Working Hours Adjustment Act (*Waa*), aims to stimulate flexible working by giving employees more possibilities to work at home and to work at hours more favourable to them. Besides an adjustment of the number of working hours (which was already possible under the *Waa*), the Flexible Working Act also provides for an adjustment of the working hours and the place of work. This does not involve an unconditional right to work at home. The statute regulates the right to apply for a permission to work at home. The employer may turn down the request to adjust the number of working hours or the working hours due to serious business reasons. The Dutch Working Hours Act (*ATW*) also explicitly recognises the employee's control over his or her working hours and the pattern hereof. In determining these, the employee's personal circumstances outside work should be taken into account to the extent that this is reasonably possible. Personal circumstances explicitly also include care tasks for dependant family members, relatives, and loved ones (Art. 4:1a of the Dutch Working Hours Act (*ATW*)).

Finally mention can be made of a 'time arrangement' with an explicit focus on informal caregivers: respite care, where professionals or volunteers take on the care tasks of informal caregivers. Respite care may be used on an occasional basis, but it can also be used on a structural basis. In the latter case the working informal caregiver can take leave, e.g., for a part of a workday on a weekly basis or for a weekend on a monthly basis. Respite care is often paid under the Dutch Long-Term Care Act (*Wlz*) or out of a personal care budget (*pgb*), depending on the required provisions. Local authorities may also offer financial support under the Dutch Social Support Act (*Wmo*).

Services

Under the Social Support Act (*WMO*) adopted in 2007 Dutch local authorities have a duty to organise support for informal care. The support offer varies widely and ranges from individual to collective services, from a general to a purposive offer. An assessment by the Netherlands Institute for Social Research (*SCP*) of the Social Support Act (*Wmo*) in 2014 showed that support offered by the local authorities to informal caregivers mainly consists of: information (96%), advice, support and coaching (94%), respite care (82%), education and training (83%), emotional support (76%) and practical assistance (70%). Local authorities also organise events, such as meetings or contact with other informal caregivers, to relieve the burden of informal caregivers and to express their appreciation to them. Occasionally local authorities mentioned their mediation in voluntary efforts, e.g. to strengthen a network or for specific chores, the offer of a subscription to ShareCare (digital tools, e.g. to organise the logistic issues related to informal care) or a solution for a housing problem such as a sheltered accommodation linked to a care home. In addition various initiatives to support informal caregivers are developed in the market, e.g. apps aiming to link supply and demand and to facilitate the organisation of informal care. Technological developments boost these initiatives and create new possibilities.

6. The enabling and facilitating of informal care in Germany

The support of employees providing informal care in Germany also comprises a broad range of instruments. This section describes the different dimensions of time, money and services.

Time and money

In Germany under the Care Time Leave Act (*Pflegezeitgesetz, PflegeZG*) which entered into force in 2008 and the Family Care Time Leave Act (*Familienpflegezeitgesetz, FPfZG*) which entered into force in 2012 employees who are in need of caring time have three options, i.e. the short-term care leave (*kurzzeitige Arbeitsverhinderung*) of ten leave days (comparable to the Dutch short-term care leave) and two types of long-term care leave: the care time leave (*Pflegezeit*) and the family care time leave (*Familienpflegezeit*). The care time leave lasts six months and can be taken either full-time or part-time; the family care time leave can be taken for a maximum of two years, but only part-time. To stay in touch with the labour market the employee must continue to work a minimum of fifteen hours a week. The emphasis of the family care time leave is thus on employees working full-time or in substantial part-time jobs. The maximum length of a care leave applies per care recipient per calendar year. Employees with an extensive family circle may therefore take care leave several times a year. During these three types of care leaves a far-reaching prohibition of termination of employment by the employer applies protecting the employee against the risk of dismissal.

Employees can always claim the short-term care leave, regardless of the company's size. This right is enforceable without reservations. This is different for the care time leave and the family care time leave. Here an enforceable right that cannot be refused only exists if an employer as a rule has fifteen or twenty-five employees respectively. In cases of care time or family care time the employer is under no obligation to agree to the employee's proposal for a

division of working hours if urgent business interests are contrary to the employee's wishes. Employees are bound by the leave period agreed upon and require the employer's permission for a premature termination of the leave.

The three types of leaves are possible for a wide circle of relatives. As of January 1, 2015, this circle also includes the stepfather, stepmother and stepchildren. Employees are only entitled to a leave if the relative is in need of care as defined in the long-term care insurance (*Pflegeversicherung*) and lives at home. This may be either the home of the person in need of care or the home of the informal caregiver or of a third person. This 'home requirement' is in line with the legislator's endeavour to support non-residential care. However, as of January 1, 2015 this requirement has been eased. For minors and for the support of relatives in the last phase of their lives the right to a leave also exists when the person in need of care was admitted to an institution.

As of the introduction in 2015 of two Acts on the Improvement of Care (*Pflegestärkungsgesetze*) the financial position of the person taking leave has improved. Employees are entitled to an interest-free credit provided by the state. For the part-time family care time the credit amounts to half of the loss of income suffered by the leave. With regard to care time a credit ceiling applies, protecting the employee against excessive financial costs in the repayment phase (Bundestag printed matter 18/3124, p. 35). The credit amount is limited to half of the loss of income pertaining to a leave period of 25 hours and therefore also applies to the full-time type of leave. The right to an interest-free credit exists in all companies irrespective of their size. The credit is repaid monthly after the leave when the employee is back to his/her former number of working hours again. If the employee is unable to repay, e.g., due to disability or death, the state will bear these costs.

During the short-term absence from work (10-day leave) employees are entitled to a wage compensation. This compensation amounts to gross ninety per cent of the lost net income (up to a maximum income). This so-called *Pflegeunterstützungsgeld* (care benefit) is paid by the long-term care insurance (*Pflegeversicherung*) of the person in need of care; due to this measure the premium of this insurance increased by 0.3%.

The first assessment of the Advisory Committee for the Compatibility of Care and Work (*Beirat für die Vereinbarkeit von Pflege und Beruf*), carried out in 2019 by order of the Federal Ministry of Family, Seniors, Women and Youth shows that the use of the leave forms lags behind the government's expectations as laid down in the Acts on the Improvement of Care (*Pflegestärkungsgesetze*) (Unabhängiger Beirat für die Vereinbarkeit von Pflege und Beruf 2019, pp 44-45.).

Another option, besides the care time, family care time and short-term care leaves, is a reduction of working hours under the *Teilzeitbefristungsgesetz*, the German equivalent for the Dutch Flexible Working Act. As in the Netherlands, the employer can only refuse a request by the employee in case of substantial business interests.

With regard to working time, there is little support for informal caregivers. The Working Time Act (*Arbeitszeitgesetz*) only focuses on employees working in shifts. If they have a duty of care toward a relative or loved one in need of substantial care, they may be exempted from working in shifts, unless compelling business interests prevent this.

The Act does offer the possibility to deviate in collective labour agreements from the relatively strict Working Time Act for the benefit of the employee with care responsibilities.

Services

Informal caregivers, whether they perform paid work or not, often face all kinds of practical problems. For that reason, the legislator has established care support centres (*Pflegestützpunkte*) to inform and advise informal caregivers and thus help to prevent persons from being involuntarily admitted to an institution. There are courses for informal caregivers as well. These are offered by several organisations such as health insurance companies, community centres, charities, social work etc. and can be taken in the residential environment of the care recipient. Online courses are being developed. The courses cover a wide range of subjects and may relate to auxiliary materials and home adjustments, to learning nursing skills (heartrate, blood pressure, body care, preventing decubitus and thrombosis, terminal care, etc.) or to the exchange of experiences with other informal caregivers. The costs of these courses are generally paid for by the long-term care insurance of the care recipient. Services offered also include arrangements to replace informal caregivers. Daycare (*Tagespflege*) enables persons in need of care to stay at a residential facility for a couple of hours a day. Two forms of respite care, *Kurzzeitpflege* and *Verhinderungspflege* allow the admission to an institution for a maximum of eight weeks a year and the replacement of informal care by professional care for a period of six weeks a year respectively. The long-term care insurance pays a fixed fee for these services. One is also entitled to this fee in case the person in need of care is staying abroad (The Federal Social Court (BSG) 20.04.2016 – B 3 P 4/14 R).¹¹ Finally, on certain conditions informal caregivers may take a recovery cure (*Erholungskur*) which is paid for by the long-term care insurance.

By means of the above-mentioned regulations the legislator aims to strengthen and improve the social commitment with and the quality of long-term care. The objective is to support informal caregiving and to reduce the chances of physical and mental overburdening of informal caregivers. It is in keeping with this objective to arrange insurance for informal caregivers, who provide informal care for a minimum of fourteen hours and have paid work not exceeding thirty hours a week, against accidents that happen while giving informal care.

Employees who for reasons of family care have refrained from paid work for some time and who after their care time wish to re-enter the labour market, can also receive reintegration assistance. This assistance may consist of coaching and mediation. Furthermore, persons who re-enter the labour market and never completed a vocational training may under certain conditions get the costs of an education or a training reimbursed.

7. Future issues: what can we learn from the comparison between the Netherlands and Germany?

In many European countries there is a lively discussion on the ways of facilitating the combination of paid work with both care and informal care tasks. Both societal and policy changes contribute to the urgency of this issue. The rising

¹¹ In this case a relative takes care of a person needing care. Together they go to Switzerland on holiday. A third person travels along to provide respite care. The Federal Social Court (*Bundessozialgericht*) ruled that, apart from the care costs, travel and accommodation expenses of this third person must be paid by the long-term care insurance as well.

life expectancy and the rising number of chronically sick patients cause a growing need of care and at the same time the ageing population increases the pressure on labour market participation. Many countries have reformed the systems of long-term care for the elderly, the chronically sick and disabled persons.

This paper has shown that the solutions of the Netherlands and Germany more than comply with the EU work-life balance directive which introduces a new right of carers' leave of five working days per year per worker (article 5) and strengthens the right to request flexible working arrangements to carers (article 9). The Netherlands and Germany however came up with different solutions to support working informal caregivers. A partial explanation of the differences is of course the fact that the said countries have a different 'starting position'. Germany has traditionally had a more familial system, in which the family is primarily responsible for the well-being of the individual. The Netherlands on the other hand has witnessed a long process of 'defamilialization' of care activities: long-term care became collectivised to a large extent with the state offering several services, and informal care playing a less significant role.

At the same time these differences are based on different choices. The facilitating and enabling of working persons who combine roles and tasks are organised in a different way. What strikes one is that in Germany both time and money are important instruments and that the employer is not affected with regard to the financing of leaves.

The German legislator, as compared to the Netherlands, has opted for relatively long leave forms and for a far-reaching protection. In companies of a certain size the German leave forms grant the employee an enforceable right, whereas the Dutch rights to a leave are conditional. In the case of family care time, one does not lose touch with the labour market as one is required to continue to work a minimum of 15 hours a week. Another point of difference is that in Germany the leave period is related to the person in need of care and not, as is the case in the Netherlands, to an absolute maximum number of leave days per employee a year. Furthermore, the German leave regulations as compared to the Dutch ones contain a strict prohibition of dismissal. Finally, informal caregivers who due to care obligations quit working altogether have specific rights to support when they re-enter the labour market, such as coaching, mediation and training.

As of the implementation of the Acts on the Improvement of Care (*Pflegestärkungsgesetze*) in 2015, all leave forms in Germany contain a provision for the compensation of loss of income. The loss of income in both types of long-term leave is limited to half of the number of hours one works less and is borne by the leave taker and the state jointly. The employers in Germany play no role here. Both the care time leave and the family care time leave in Germany are financed by means of a credit, whereas in the Netherlands the long-term care leave, except for certain arrangements in collective labour agreements is unpaid. Employers in Germany are also off the radar as regards the short-term ten-day leave. The full loss of income is reimbursed by the long-term care insurance (*Pflegeversicherung*) of the person in need of care and not, as in the Netherlands by the employer. The enabling in Germany, as compared to the Netherlands, thus appears to be more of a shared responsibility where the state and the individual are jointly responsible.

In finding a 'solution' to the issue of enabling the working informal caregiver, the focus in the Netherlands until now has been more on the specific Dutch working hours regime and less on an extension of the leave facilities. Part-time work and the possibility of adjusting working hours offer the 'valve' for the increasing pressure of combining work and care. The financial risk of combining work and informal care is then borne mainly by the individual and the employer.

Only in the area of the practical support of the informal caregiver/caregiver services does the government in the Netherlands play a role. Here local authorities have an overall steering function with regard to the strengthening of the position of informal caregivers, the linking of informal and formal support and care and the easing of informal care.

In view of the societal and demographic changes one may wonder whether the Dutch approach to enable and facilitate informal care will be sufficiently robust to reduce the risks of combining work and care in the future. Two issues are prominent. First, the enabling of the working informal caregiver who provides long-term and/or intensive informal care and second the enabling and facilitating of certain social groups in society who give informal care.

The first issue is a complex one, as there is a wide range of intensive or less intensive informal care in relation to the help given, the informal caregiver and the person in need of care. Given this diversity the need for support also varies. Some informal caregivers will benefit from flexible working hours and working at home, others will benefit from practical support, e.g., services, so that certain tasks can be outsourced, or there may be a need for respite care. The question is how to respond to this diversity and how to organise this enabling (in a society where everyone also participates in the labour market).

The German organisation of the family care time, where one opted for a more public arrangement and a uniform regulation, might offer leads for this question. Support for long-term and/or intensive informal care is offered not only in the form of time, but also in the form of money. It should be noted, however, that it is still too soon to draw lessons from the German situation, simply because the measures there have been adopted fairly recently and insight into the use thereof is still limited; there also is no clear picture yet of the effects of such long-term leaves on e.g., labour market participation.

In the meantime, for the Netherlands a study could be made on both the advantages and the disadvantages of a credit arrangement with a repayment obligation in the Dutch context and on the question whether such an arrangement would offer a good supplement to the existing collective labour agreement provisions. One advantage of a credit arrangement is that this instrument will in all probability not often be used improperly, as it is the employee him or herself who pays the income supplement. A disadvantage may be that the low-wage groups will have limited access to such an arrangement.

The second issue refers to the question whether certain social groups in society have sufficient possibilities at all to be able to combine. This also relates to the changes that take place in the labour market, such as the increasing number of self-employed workers without employees and the process of flexibilization in the labour market. Self-

employed workers have access to the arrangements to a lesser extent than employees. On the other hand, when the leave is unpaid self-employed workers, as long as they are their own boss, have no need for an enforceable right to time. For flexible workers and less educated persons it is less easy to invoke the arrangements on combining work and informal care. Less qualified work often offers less opportunities for flexibility of time and place, and from a financial point of view it is less practicable for this group to take leave.

This issue thus touches upon a broader debate in the Netherlands on the fast growing numbers of self-employed persons without employees and of employees with a temporary contract. These groups experience more uncertainty as regards their income and social security. The German arrangements provide no ready-made solutions to enable these specific groups either. In practice the leave system is mainly accessible to employees with a permanent contract, and the credit facility favours employees who are employed on a (more or less) permanent basis.

The comparison shows that it is far from easy to formulate an appropriate answer to both issues. A clear lesson to be learnt from the comparison is that the German situation shows that despite the emphasis on informal care more support is offered, and that the government continues to play an important role in the enabling of informal caregivers, in particular when they provide intensive and long-term informal care. Informal care is not only a responsibility of the individual and/or the employer. This choice can also be defended based on efficiency arguments. It is not possible to take out an insurance against the provision of informal care on the private market, as this involves a non-insurable risk (due to the nature of the risk, which is too influenceable). Furthermore, providing informal care, especially intensive and long-term informal care, has negative external effects related to a reduction of labour market participation and the ensuing costs for society (Barr 2004 and Koopmans 2007).

The government should therefore play a role in facilitating and enabling working informal caregivers. The more so in a society in which various roles and tasks will increasingly be combined and in which working persons will become increasingly responsible for providing informal care.

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