COLLECTION OF **GOOD PRACTICES**

OF SOCIAL DIALOGUE AND STAFFING IN SOCIAL SERVICES

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Team of authors

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The photographs used come from the archives of the partner organisations or were taken by the participants in the study trips.

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Content

Introduction

This collection is the outcome of the international project *Exchange of experience, knowledge and know-how in the field of social services staffing*, which was implemented during the period from 1 October 2019 to 31 March 2022. For the purpose of implementing the project, a partnership was established between social service organisations with similar objectives and activities from the Czech Republic, the Netherlands and Finland. The project partners included the Association of the Providers of Social Services of the Czech Republic (APSS CR) as the project coordinator, the ActiZ from the Netherlands, and the Hyvinvointiala HALI ry from Finland (HALI).

All the partner organisations focus in their activities on improving the quality of the provision of social services and are highly active in collective bargaining and social dialogue. The APSS CR as an independent association of legal and natural persons and registered social service providers represents and protects the interests and needs of its members vis-à-vis state institutions and other stakeholders and performs many other activities as well. In Finland, the HALI ensures the negotiation of national collective agreements in social services, monitors the joint interests of its members and provides consultancy on issues of employment and trade policy. The ActiZ is a social service employers' organisation with 400 thousand employees. The ActiZ have created together with trade unions educational standards and certify educational institutions in the Netherlands.

The project is focused on the transfer of experience, knowledge, know-how, and good practices in social dialogue, collective bargaining, and other factors relating to employment in social services. The project responds to major issues in the social services sector, which is the fastest growing sector in Europe in terms of creating new jobs. At the same time, however, the social services sector faces a shortage of skilled labour. Therefore, it is necessary to systematically focus on adjusting the remuneration system, working conditions, supervision, support, and training of employees. By sharing knowledge, examples of good practice, information, and experience in these areas, we want to optimize the existing activities of the individual project partners and expand, target and improve them, but also create long-lasting professional partnerships.

The transfer of experience, knowledge, know-how, and good practices occurred through 3 study trips in the partner countries. Each of the study trips included workshops, seminars, visits to government agencies, local governments, social service providers, and social partners. The study trip programmes focused on comparing the working conditions and the working environment for employees in social services, on occupational safety measures, qualifications and lifelong learning, supervising and supporting employees, as well as on their remuneration. The aim of the workshops, presentations and field trips also was to make the participants familiar with the activities, educational programmes and projects in recruiting and retaining employees in social services, reducing staff turnover, and making the individual social service professions more attractive.

1. Czech Republic

As of 31 December 2019, the total of 10,701,777 people were living in the Czech Republic.[1] The Czech Statistical Office distinguishes three major age groups – children below 15 years of age, the working age population from 16 to 64 years of age, and the 65+ age group of senior citizens. It was in the senior citizens age group where the largest increase – by 26.7 thousand – was recorded in 2020. In total, there are 2.158 million of persons in this category, which is an increase compared to 2019. For the first time in the history of the Czech Republic, the level of two million of senior citizens was exceeded in 2017. This is clear evidence that the population ageing process continues. The average age of the population reached 42.6 years in this period. Population projections predict that in 2059 there will be 3.205 million of people over 65 years of age living in the Czech Republic. This is an increase by 1.047 million (by 32.6%) compared to 2020.[2] This is indicative of the growing necessity and importance of the social services sector. Generally, it can be stated that the social systems in the Czech Republic had to go through a major change after the social changes following the end of the Communist party rule in 1989. The entire reform was built on three pillars – social assistance, social support and social insurance. The first changes were enacted as early as in 1995 (sickness insurance, pension insurance, minimum subsistence level, state social support), but the entire process lasted until 2011, when it was finished by the adoption of the Act on Provision of Benefits to Persons with Disabilities and on Change of Related Acts. An actual Social Services Act was adopted together with the Act on Assistance to Persons in Material Need after more than ten years from the reform launch as late as in 2006, with effect from January 2007. One of the first acts which we include in the social reform was the Sickness Insurance Act. Within the Czech system of so-

[1] *Czech Statistical Office, Population Statistics Division - Population Development of the Czech Republic (https://www.czso.cz/documents/10180/142755448/13006921.pdf/c2f581b5-19a5-4c55-bfde-020bfe16c155?version=1.1).*

[2] *Czech Statistical Office, Population Statistics Division - Population Development of the Czech Republic – 2018–2100 (https://www.czso.cz/documents/10180/61566242/13013918u.pdf/6e70728f-c460-4a82-b096-3e73776d0950?version=1.2)*

cial protection of the population, the sickness insurance and the health insurance systems are designed as separate.

Social services in the Czech Republic are defined in Act No. 108/2006 Coll., on Social Services, in Sections 32 to 70. Under the new legislation, social services are divided into three areas:

- Social counselling
- Social care services
- Social prevention services

The act also contains a classification of the forms in which these services may be provided. This includes:

- **Stay-in services** – services involving the accommodation in social services facilities.
- **Ambulatory (outpatient) services** – services provided in social services facilities which a person attends or where a person is accompanied or transported, where accommodation is not part of the service.
- **Field services** – services provided to a person in such person's natural social environment.

The individual forms of social services are combined to ensure their maximum efficiency. The basic activities during the provision of social services are defined in Section 35 of Act No. 108/2006 Coll., on Social Services, as amended, and the scope of the performances provided within a basic activity for the individual types of social services is given by an implementing regulation (Decree No. 505/2006 Coll.).

To be able to carry out its activity, a social service provider must fulfil the condition of obtaining registration and subsequent addition in the Social Services Provider Register. Registration is also one of the prerequisites for the use of funds from public budgets. The Social Services Act does not require registration:

- where the assistance is provided to a person by a close person or another physical person who is not performing such activity as an entrepreneur;
- where a physical person or a legal entity is based in another European Union member state, if such person provides social services under this Act in the territory of the Czech Republic only temporarily and sporadically, subject to proving that the person is:
  - a citizen of a member state of the European Union or has its registered office in another member state of the European Union;
  - a holder of the authorization to perform activities specified in Section 84(1) of the Social Services Act under legal regulations of another member state of the European Union.

Foreign nationals have a notification duty towards the competent regional authority, which they must inform about commencement of their activities. They only may commence their activities as of the day of this notification.

An entity providing social services without registration commits an offence which may be punishable under Act No. 108/2006 Coll., on Social Services, by a fine of up to CZK 2 million.

The individual types of social services are defined by several characteristic features, including in particular the form of provision (field, outpatient and stay-in services), the group of persons at whom a service is targeted, and the enumeration of the basic activities that have to be offered to clients. At the same time, services must be provided in accordance with the quality

standards – a set of fifteen criteria the compliance with which is examined by the quality inspection of the Ministry of Labour and Social Affairs of the Czech Republic (MoLSA). The goal of these standards is to create an ideational and a referential framework for the provision of social services.

Social services quality standards:

- **Goals and methods of providing social services**
  Each provider should define the mission, the goals and the working procedures for their organisation, as well as the target group they wish to work with. This information should be provided in writing and be freely accessible. Each provider should respect the opinions and the will of their users.

- **Protection of a person's rights**
  Providers should lay down written rules to prevent situations where the provision of a social service might result in the violation of the fundamental human rights and freedoms of users or in a conflict between the interests of the provider and those of the users. The provider should also lay down written rules for the acceptance of gifts from users and their families.

- **Dealing with an applicant for a social service**
  For a more efficient and easier search for a suitable social service for a user, providers should prepare an offer of the services provided, define their conditions and designate a worker who will discuss with the applicant their requirements and the possibilities of a given service. The outcome is either a concluded contract or the existence of reasons for which the applicant may not be accepted. In the event of a refusal, the given worker must give advice on how to continue in the search for the service needed.

- **Contract for the provision of a social service**
  When entering into the contract, the provider should take into account the individual abilities of users and ensure that the new user or their agent understand the content and the purpose of the contract. The contract should provide information on the scope and the progress of the services with view to the personal goal depending on the capacities, abilities and wishes of the user.

- **Individual planning of the provision of a social service**
  Within the framework laid down by the contract, a permanent process of individual planning takes place, making it possible to verify the fulfilment of the planned performances and the personal goals of the user and to make adjustments, if necessary. The provider must enable the user to express their will, opinions and possibly also emotional reactions. An individual plan is implemented as part of the provision of the social service. An information system should be created for the collection and sharing of information among employees on the progress of the provision of a social service to users.

- **Social service provision documentation**
  The provision of social services to users must be recorded in the relevant documentation, with regard to statutory obligations (such as medical documentation) and the needs of the social service provision process. Where legislation does not provide any documentation retention period, such period must be determined by the provider.

- **Complaints about the quality or manner of providing a social service**

  One way in which users may voice their dissatisfaction with the manner in which they receive the social service is official complaints. The handling of complaints should be transparent and objective, the complaints submission and clearance rules should be laid down in writing and all employees must be familiar with them. A user must have the option to choose an agent for the submission and clearance of a complaint. Complaints must be recorded and cleared in writing within an adequate time limit. Where a user is not satisfied with the outcome of their complaint, the provider must inform the user on the option to bring the issue to a superior body or a human rights institution.

- **Connection of the provided social service to other available resources**

  The provider should not substitute commonly available public services with its own activity. On the contrary, users should be encouraged to use the available public services such as shops, cinemas, theatres, libraries, hairdressers and other services and to maintain former contacts and relations with their natural social environment.

- **Social service staffing and organisation**

  Providers must have an organisational structure defined, including the numbers of job positions, job profiles, qualification requirements and personal characteristics of workers in social services, proportionately to the type of the provided social service, its capacity, and the number and needs of users. The provider must prepare rules for staff management in its organisation, rules for the hiring and training of new employees, or training and work of volunteers.

- **Professional development of employees**

  A system of further education must also be part of a provider's corporate culture. Employees should have an individual further education plan. An important aspect of employee development is their motivation. Providers should have transparent remuneration rules and a system of moral recognition of employees. Important for a successful provision of social services is information flow. A provider must have a system for exchange of information among employees in real time in order to be able to continually ensure an excellent and secure provision of a social service.

- **Availability of a provided social service in terms of place and time**

  The place and the time of the provision of a social service is determined by the provider. This must be done with regard to the type of the service, the group of users and their individual needs.

- **Awareness of a provided social service**

  Each provider must present its service not only to prospective but also its current users. To that end, a provider must have readily available a clear set of information on a given social service.

- **Environment and conditions**

  Social services should be provided in adequate material, technical and sanitary conditions adequate for the type and capacity of the service. The adequacy assessment is made on the basis of legal regulations such as the healthcare regulations regulating sanitary conditions or the

construction regulations defining the required parameters of buildings with view to their declared use.

- **Emergencies and accidents**
  Within its activity, a provider must anticipate and define in writing potential emergencies and accidents and prepare realistic procedures for their management. All employees and users must be provably made familiar with these plans. At the same time, a provider must create conditions ensuring that these plans will be successfully applied.

- **Social service quality improvement**
  The process of providing a social service must be continually evaluated by means of user satisfaction inquiries, assessment of employees and other individuals and legal entities involved. Another source of evaluation are the submitted complaints about the quality or manner of providing a social service. The evaluation results serve as basis for developing and increasing the quality of a social service.

1.1 Equipment of the regions of the Czech Republic with social services for senior citizens

The need for care in all European countries has been viewed as a new social risk in recent years. A unified definition of this term does not exist, nevertheless it is understood, as a rule, as a long-term or permanent loss of self-sufficiency in everyday activities. The criteria frequently used to define the need for care are the ADL (Activities of Daily Living). This includes the ability or disability to dress and undress oneself, manage one's own personal hygiene, put oneself in bed and get up, and move in one's own flat. In general, care to senior citizens in the Czech Republic is most frequently provided in their own households through a social care service. Year 1990 brought the development of additional forms of services, primarily outpatient ones; but their offer is not evenly distributed over the territory of the country.

The structure of the forms of the individual social services is given by the geographical profile of a region: the availability of social care services in regions with a predominantly flat profile will be higher than in regions with a predominantly mountainous profile. In those regions, on the other hand, homes for the elderly are more frequent. To assess the scope of the services provided in the individual regions, one cannot apply the same criteria over the entire territory. We have to remember that there are objective characteristics which determine certain differences ensuing from, for example:

- the population structure of the individual territorial units, the size of a municipality and the population density;
- urbanisation rate;
- the structure of the population in a given territory in terms of age, qualification, profession and social structure, as well as the religious specifics of individual regions;
- the level to which the care for the elderly is secured by the traditional functions of the family;
- various sociological changes taking place in the society, particularly the break-up of multi-generational families.

All in all, we can say that the offer of social services in the Czech Republic is insufficient from the quantitative viewpoint. The waiting periods

for placement in homes for the elderly are long and the offer of field social services is insufficient – these are the major issues which social care providers have to deal with basically in all the regions of the Czech Republic. The fundamental role in this issue is played by the existing system of funding social services. It is based on a high level of central regulation and dependence of social care providers on subsidies from the national budget, to which no legal entitlement exists.

A considerable proportion of the care provided to senior citizens in the Czech Republic is made up by stay-in social services. Nevertheless, the elderly very often wish to stay in the flat they are familiar with for as long as possible. Individual living in an environment familiar to a senior citizen with the maximum support from relatives and the professional workers of outpatient services is the prevailing manner of living.

Client needs and their satisfaction by individual social services are accurately defined, not only by the given legislation but also by the qualifications of workers. If the health condition of a social care user aggravates, in most cases he or she is automatically moved to a stay-in facility. Both these forms (in a stay-in facility and in a natural environment) constitute a significant labour, economic as well as cost factor. It is expected that this development will continue in the upcoming years, considering the demographic development and the gerontological trends.

Significant emphasis is placed on the level of education of workers and their life-long learning in the Czech Republic. From the perspective of the quality of the provided social services, this fact is a strength, nevertheless, the low level of financial rewards results in a high labour migration. The high employee turnover might be reduced by increasing salaries to a level comparable to those paid to the workers in similar categories of work in hospitals or by introducing flexible work schedule allowing workers to balance their profession and their family obligations.

Another such measure that might prevent employee turnover is to increase the motivation and satisfaction of workers and nursing staff by the management and to focus on keeping older and more experienced staff. Another important factor is the promotion of health for the prevention of overwork and the burnout syndrome.

1.2 Funding of social services

Social services in the Czech Republic are funded from multiple sources, through a combination of public (national budget subsidies, regional and municipal budgets, health insurers, and European Social Funds) and private funds (payments for care and other payments). Since 2013, the costs of the social service system have been continually growing, which lead to the increase in funding from both public and private sources. The crucial source of funds for social services is the subsidies from public budgets, the care allowance, and the reimbursements of nursing and rehabilitation care from public health insurance. The expenditures on the provision of social services are constantly increasing.

1.2.1 Care allowance

The care allowance is provided to persons who are dependent on another person's assistance under Act No. 108/2006 Coll., on Social Services, as amended by later regulations, and Decree

No. 505/2006 Coll., Implementing Certain Provisions of the Social Services Act, as amended by later regulations. Through this allowance, the state participates in the provision of social services or in other forms of assistance for ensuring self-sufficiency. Eligible for this allowance is a person who needs the assistance of another physical person for the purposes of self-care due to their long-term unfavourable health condition and for ensuring self-sufficiency, where this assistance is given by:

- a close person,
- a social care assistant, or
- a registered provider of social care.

The dependence on another person's assistance is divided in four degrees. For old persons who are not self-sufficient due to their long-term unfavourable health condition the degrees of dependence are the following:

- **Degree I** (low dependence) – a person is not able to cope with three or four acts of self-care and self-sufficiency;
- **Degree II** (medium dependence) – a person is not able to cope with five or six acts of self-care and self-sufficiency;
- **Degree III** (heavy dependence) – a person is not able to cope with seven or eight acts of self-care and self-sufficiency;
- **Degree IV** (total dependence) – a person is not able to cope with nine or ten acts of self-care and self-sufficiency and needs daily assistance, supervision or care from another individual.

When determining the dependence degree, the self-care and self-sufficiency domains assessed stem from the Katz Index of Independence in Activities of Daily Living, and include:

- Mobility
- Orientation
- Communication
- Feeding
- Dressing and putting shoes on
- Personal hygiene
- Toileting
- Care for one's own health
- Personal activities
- Household care

When assessing the ability to cope in the individual self-care domains, considered is the functional impact of a long-term unfavourable health condition on handling these simple acts. For dependence in a particular self-care domain, there must be a causal link between the functional capacity disorder caused by unfavourable health condition and the loss of ability to handle an act of self-care at an acceptable standard. A functional capacity is assessed with the use of individual's remaining potential and competences and with the use of commonly available aids, objects of everyday use, appliances or home equipment, public spaces, or the use of a medical device.

Amount of care allowance

The allowance provided to persons over 18 years of age in a calendar month amounts to:

- CZK 880/EUR 39 for degree I (low dependence),
- CZK 4,400/EUR 170 for degree II (medium dependence),
- CZK 12,800/EUR 340 for degree III (heavy dependence),
- CZK 19,200/EUR 515 for degree IV (total dependence).

The total number of persons receiving a care allowance in the Czech Republic is over 370 thousand.

Aside from the care allowance, there are also other allowances provided in the Czech Republic within the regime of assistance to persons in material need or allowances for disabled persons. The allowances within the assistance to persons in material need are, as a rule, paid on the basis of the assessment of the overall social and income situation of applicants and their families. The allowances to people with disabilities are paid based on the assessment of the social consequences stemming from the applicant's disability. Also in this case, the applicant's overall income situation is considered.

From 1 June 2018, long-term nursing care has been introduced as a new tool in sickness insurance. This tool will provide employees security for a period of up to 3 months when they assume care of, for example, a parent dependent on another person's assistance following a minimum of one week hospitalisation.

1.2.2 Subsidy scheme

The subsidy scheme for funding social services in the Czech Republic is very closely tied to ensuring tasks by regions within the social service system. Regions are bound by law to ensure the availability of social services in their territory and comply with the medium-term social service development plan. Regions ensure the availability through a network of social services, having full competence over their structure, while considering information on the needs of the population obtained from the municipalities in the region. For the fulfilment of this obligation, the Ministry of Labour and Social Affairs of the Czech Republic ("MoLSA" or "Ministry") provides subsidies. A subsidy may only be used to finance common expenditures connected with the provision of the basic types and forms of social services within the scope determined by the basic activities within the individual types of social services. To be eligible for a support for the provision of social services, one has to be part of the network of the social services specified in the medium-term social service development plan of a given region.

The amount of the subsidy for the individual regions is calculated from the total volume of the national budget funds allocated to the MoLSA chapter as a percentage for a particular region (guidance value). The percentage shares in the subsidies for each region are given by an annex to the Social Services Act. Where a region applies for a subsidy lower than the determined percentage, the subsidy is determined at the amount required in the region's application for subsidy. The system of granting subsidies to regions is also affected by EU legislation, specifically through the application of the rules on state aid to businesses providing services of general economic interest.

For a given year, the MoLSA announces Subsidy Priorities reflecting the selected needs of the Czech Republic and thereby defines the aid to social services which, for instance, ensure the care for specific target groups (e.g. persons with autism spectrum disorders). The Subsidy Priorities also take into account the funding of a given type of services, such as in the context of other sources of funding which is not continuous (e.g. social prevention services, which are partially funded from the resources of structural funds). The MoLSA Priorities are published in the "Call for applications for a subsidy from the national budget submitted by regions and the capital of Prague".

The national budget subsidy is intended to finance common expenses on social services, except for health care, despite the fact that in some social services the provision of health care is the central activity. In this respect, the provision of a subsidy is restricted because the funding of health care in the Czech Republic is ensured strictly from the funds of health insurance companies.

The subsidy principles are in compliance with the Ministry's long-term priorities in the social services system. This is why the priorities include such services which preferentially enable their users to live in their natural environment, their homes and local communities.

MoLSA's goal in the subsidy proceedings is to rule out any conflict of interest, ensure equal access to funding for all social service providers regardless of their legal form. An important role within the decision-making on subsidies to regions is also performed by the subsidy commission, which is an advisory body of the minister and which prepares recommendations on decisions to provide a subsidy. The subsidy commission consists of the relevant agents of the social service system, which include: the public administration, social service providers and agents of employees in a given sector.

1.2.3 Financial sustainability challenge

The National Strategy for the Development of Social Services 2016–2025 states that with regard to population development and the growing number of users, the current system of funding social services is unsustainable.

With the current model of funding and legislative regulation of social services in place it would be very difficult to support persons with reduced self-sufficiency to live independently (MPSV/MPSV, 2015b). The strategy correctly identifies several causes for such assessment, pointing in the first place to the lack of reliable data on social service funding, which makes impossible any relevant comparison or count (ibid.). No relevant assessment of efficiency can be performed.

Subsidies from public budgets constitute a crucial source of funding primarily for non-profit providers. These subsidies are paid out within a subsidy scheme for one year and providers are never sure whether their project will succeed the next year. In this scheme, long-term planning, personnel policy, innovation and investments are improbable and the position of clients is, of course, uncertain. The current strategy, as an official document endorsed by the cabinet (Government Decree No. 245/2016), even requires the introduction of obligatory subsidies from the central government budget. This would create a revolutionary precedent in the public finance system and it would be very surprising if the government actually made such a policy change. A more realistic alternative seems to be the introduction of something like a medium-term contract.

1.3 Education of employees in social services

Education for the social services sector in the Czech Republic is regulated by the Social Services Act. This legislation applies to all types of

social services regardless of their focus (target group of clients). The Act also regulates the education of social workers, but here it goes beyond the domain of social services and applies also to social workers employed by municipalities and regions or in other services using social workers (such as health care). Legislation distinguishes two levels of education:

- Qualification education – education which an employee must complete to be able to perform a job in social services
- Further education

Qualification education of social workers

The basic activities of a social worker include, for example, social investigation, handling social agenda, which includes resolving social legal issues in facilities providing care for the elderly. Social workers also carry out screening activities (screening for persons at risk of social exclusion), provide crisis assistance, social counselling and social rehabilitation, provide for the needs of the inhabitants of a municipality, and coordinate the provision of social services at community level.

Legislation also assumes that social workers acquire their qualification through study at:

- a higher vocational school in fields focused on social work and social pedagogy, social law activities, social and humanitarian work, charity and social activities;
- university-level education acquired in Bachelor's, Master's or doctoral degree programmes focused on social work, social care, social policy, social or special pedagogy, social pathology, or social law.

Further education of social workers

The acquisition of qualifications for the performance of a profession is only the beginning of a life-long process of education and self-improvement. By law, in the Czech Republic an employer is obligated to ensure for social workers further education to the minimum extent of 24 hours per calendar year. Law also stipulates the forms of such further education. These specifically include:

- specialized education provided by universities and higher vocational schools following up on the professional skills acquired for practising the profession of a social worker;
- participation in accredited courses;
- traineeships;
- participation in trainings;
- participation at conferences.

Education of workers in social services

In contrast to social workers, workers in social services are a more differentiated group. Legislation distinguishes four groups of workers in social services. In general, a worker in social services may be defined as a person who provides direct service to persons in outpatient or stay-in facilities. Direct service involves the training of simple daily activities, assistance with personal hygiene and dressing, handling of objects of everyday use, support for self-sufficiency, and satisfaction of psycho-social needs. The same applies to cases where the users live in their own homes. In this case, added to the above-given activities is also a comprehensive care for client's household and personal assistance. Under the supervision of a social worker, a worker in social services may also carry out other activities, such as screening, educational, mobilisation and other activities involving the provision of assistance during the assertion of rights and legitimate interests of users.

To be able to perform their job, workers in social services must satisfy the qualification requirement of the minimum of basic education and the completion of an accredited qualification course. The content of the course is defined by the Implementing Decree No. 505/2006 Coll. and consists of a general and a special part.

The general part of the course consists of the following areas:

- introduction to the topic of quality in social services and the social services quality standards;
- basics of communication, development of communication skills, assertiveness, alternative communication methods;
- introduction to psychology, psychopathology, and somatology;
- basics of health safety;
- ethics of performing the profession of a worker in social services, human rights and dignity;
- basics of prevention of dependence on social service;
- social and legal minimum;
- methods of social work.

The special part of the course consists of the following areas:

- basics of care for ill persons, basics of hygiene, introduction to psychosocial aspects of chronic infectious diseases;
- mobilisation and educational techniques, basics of leisure-time pedagogy;
- prevention of ill-treatment and abuse of persons receiving social services;
- basics of teaching home care;
- internship;
- crisis intervention;
- introduction to disability issues;
- handling the behaviour of a person who is a recipient of social service if such behaviour poses a threat to the health or life of the person or other individuals, including the rules of moderate self-defence.

The prescribed minimum scope of the course is 150 lessons, of which the special part must make up at least 80 lessons. Just like for social workers, employers must ensure further education to the minimum extent of 24 hours per calendar year also for workers in social services, in order to renew, enhance and supplement their qualifications.

1.4 Social dialogue and partners in social services

In social dialogue, social services are represented by two organisations, namely the Healthcare and Social Care Union and the Union of Employers' Association of the Czech Republic.

1.4.1 Healthcare and Social Care Union of the Czech Republic (HSCU)

The HSCU has some 45,000 members in 107 organisations (of which one third, that is, 15,000 members, are in social services) and is the largest healthcare and social care union in the Czech Republic and the third largest union in the Czech-Moravian Confederation of Trade Unions (ČMKOS). Its members are employees in health care and social care and other related organisations such as secondary nursing schools, medical faculties and other institutions. The variety of the represented professions is wide, ranging from caregivers, nurses, assistants to middle management, operating staff, drivers, and others.

The HSCU includes 107 trade organisations, of which 3 are NNGO providers.

The HSCU has its representatives in four tripartite working groups:

- Social Affairs Working Group
- Healthcare Working Group
- Public Administration Working Group
- Non-profit Organisations Working Group

1.4.2 Union of Employers Associations of the Czech Republic (UEA)

The UEA is a member of the Council of Economic and Social Agreement of the Czech Republic and participates in the creation of legislation and sectoral development plans, prepares standpoints and recommendations for the public administration at all levels, develops activities of and collaboration among member associations, and promotes social dialogue.

Thirty six of its current member associations are classified in eight sections by their field of specialisation:

1. Health Section;
2. Industry and Modern Energy Section;
3. Education and training Section;
4. Insurance and Financial Services Section;
5. Social Services Section;
6. Culture Section;
7. Agriculture and Environment Section;
8. Non-profit Organization Section.

Each section is headed by a Section Director. Currently, the UEA represents over 16,000 organisations with almost 600,000 employees.

The UEA is the largest and the strongest employers' organisation representing public services in: healthcare, social services, culture, and other areas.

In its Social Services Section, the UEA associates 5 organisations:

- Association of the Providers of Social Services of the Czech Republic (1,246 member organisations)
- Czech Council of Social Services (some 100 member organisations)
- Confederation of Social Services Providers (some 200 member organisations)
- Caritas Czech Republic (some 300 member organisations)
- Diaconia of the Evangelical Church of Czech Brethren (some 40 member organisations)

1.4.2.1 Association of Social Services Providers Czech Republic (APSS CR)

The APSS CR is the largest professional organisation associating providers of social care in the Czech Republic. It was established in 1991 and associates more than 1,246 social service providers in 2,785 social services. The association is divided into 14 regional organizations and specialised sections across the country (reception centres and hostels, stay-in care, home and day care, addiction services, day centres for children and youth etc.).

The association represents and protects the interests of its members, brings and promotes the results of scientific research in the activities of social care providers, transfers experience obtained in Czechia as well as abroad, and provides education and information to its members.

1.5 Social dialogue in social services

Social dialogue in social services can be divided into bipartite and tripartite. The partners in-

clude the HSCU, the UEA, or the APSS CR, and the Ministry of Labour and Social Affairs of the Czech Republic.

1.5.1 Partners in social dialogue

Each of the three social partners in social services has different interests, issues and attitudes. The major objective of social dialogue is to accommodate their needs and find a consensual solution. The topics and suggestions are divided in two groups depending on whether the social dialogue takes place at the macro-level, the national level, on in individual organisations.

1.5.1.1 Social dialogue in social services at the national level

The Ministry of Labour and Social Affairs of the Czech Republic (MoLSA)

The interests and goals of the Ministry change with the political leadership and the Policy Statement and the Legislative Work Plan of the government in power. The main goals and objectives of the current government in social services are the following:

- Transferring the funding of social services from the state to regions
- No reduction of the amount of state subsidies in 2014 and subsequent years
- Growth of pensions
- Tackling unemployment
- Support to families with children
- Social life

The interests and goals of unions are constant in time and are subject to tripartite and bipartite dialogue both with social partners – the state, as well as employers:

- **Growth of salaries** in social services. This group is among the second lowest paid workers in the Czech Republic. They perform demanding, much needed and specialised professions. Payment of fair adequate rewards is covered by the investments for the upcoming demographic changes.
- Preservation and partial change of the **remuneration system** in the Czech Republic to ensure that workers are rewarded with view to the difficulty of their jobs and the number of years of active working life (e.g. cancellation of the tier-based remuneration).
- Kick-starting a new model of **financing social services** accompanied with adequate funds from public budgets.
- **Other topics** (such as occupational safety, collective bargaining, benefits for employers, etc.)

Union of Employers' Associations of the Czech Republic

Constant attitude in time in relation to most topics. Sometimes, differing interests may arise in certain areas among the individual groups of employers. This fact is given primarily by the two main groups of employers: public institutions (owned by public authorities) and non-profit or private organisations (firms). The main topics are the following:

- Kick-starting a **new model of financing social services**, funding accompanied with adequate financial means from public budgets.
- Promoting **legal acts** facilitating day-to-day life in organisations (reduction of bureaucracy, restriction of unnecessary rules and procedures, etc.).
- Change in the **quality management and quality control systems**.
- Gradual **increase of the number of workers in social services** (particularly in homes for senior citizens).

1.5.1.2 Social dialogue in social care facilities

Social dialogue on the "micro" level, that is, among unions and employers, is basically equivalent to bargaining a collective agreement.

Negotiation of collective agreements is provided for by the Collective Bargaining Act. Other regulations (on validity of an obligation) are provided for in Labour Code. Only an employer and a local trade union are authorised to sign a collective agreement.

As a rule, a collective agreement contains a proper identification of the parties, the subject-matter of the collective agreements, and the rights and obligations of parties. The most important part is the rights of an employee following from the agreement and the part containing employee's specific rights and entitlements such as working hours, leave, obstacles of work, severance pay under an act regulating wages and salaries, and advantages/benefits provided by the employer. A collective agreement usually covers other relating issues (not in direct connection with the performance of the job), such as collective catering, creation and use of a social fund for employees, or regulations on occupational health and safety (OHS).

Both parties are obligated to commence negotiations on a new collective agreement within no less than 60 days before the expiry of the old collective agreement.

If no agreement is reached, the parties may choose a mediator, who is an arbitrator at the same time. If the negotiators for the employees and the employer fail to come to an agreement with the mediator, the MoLSA appoints a mediator. Within 15 days the mediator shall present a conciliation agreement to both parties. If both parties do not accept this agreement within 15 days, the procedure is deemed to have failed.

According to ČMKOS, in 2002 there were 4,314 corporate collective agreements signed with 4,314 organisations. These corporate collective agreements concern 1,075,987 employees (which makes some 27%).

In social services, there are about 2,500 providers operating, of which some 200 have negotiated or are negotiating a collective agreement.

1.5.2 Manners of social dialogue

In individual organisations, social dialogue takes place in communication between the employees (represented by a trade union) and the employer represented by a statutory agent. The subject-matter of these negotiations and communication is in the first place the collective agreement, as well as other important organisational changes, working conditions, lay-offs, or other issues. Trade unions may enter into any of the already existing associations or remain separate. There may be several trade unions with one (the same) employer.

1.5.2.1 Social dialogue in social services at the national level

At the national level, the form of social dialogue is different from that at the local level, in individual organisations. Each social partner uses its communication channels and methods, some are commonly used, others are not.

To facilitate social dialogue in the social sector, a tripartite body (a working group for social issues) has been established. It consists of a del-

egation of the state (a minister and his or her deputies), employer organisations and trade unions. They discuss and adopt standpoints on all important legal acts, decisions and changes, including the Strategic Action Plan DEI, and other documents. This body meets as is necessary for Tripartite representatives, as a rule four or five times a year.

Healthcare and Social Care Union of the Czech Republic

The HSCU is a strong organisation with qualified personnel, strong position and great experts. It is undoubtedly a professional organisation which knows how to communicate with its members, the state, as well as the media, and the general public.

The main platform for achieving their goals is the tripartite plenary sessions and the individual work groups. The HSCU communicates primarily through its president in the Czech media (newspapers, TV, radio and other means). The HSCU is also in contact with parliament members, politicians and other experts. Mention should also be made of its ability to communicate with its members. The HSCU is regionally structured and regions regularly meet among themselves as well as the HSCU directorate. Its members are informed through a website and also through the organisation's printed journal.

Last but not least, there is also the bipartite dialogue with employers. Aside from regular meetings during the tripartite and plenary session period, both the social partners visit their own general assemblies and attend separate meeting to discuss their own interests and choose the right negotiation strategy particularly towards the state.

Union of Employers' Associations of the Czech Republic

The UEA has a different structure than the HSCU and therefore also a different mode of operation. The UEA has no regional organisations. Even though the UEA represents about 16,000 organisations, the representation is not direct. It is a union of associations and these associations communicate with the individual organisations (such as the Association of the Providers of Social Services, which has 14 regional organisations and communicates directly with its members).

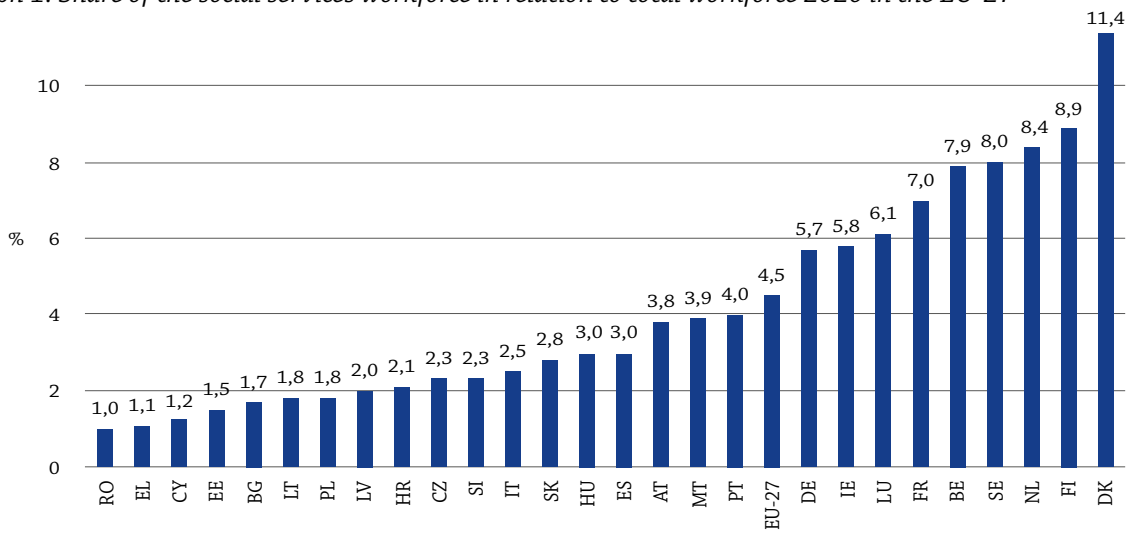
As is the case with the HSCU, the main communication channel is through tripartite teams and at plenary sessions. Also, the UEA meets and deals with government members, deputy ministers, parliament members, and other stakeholders or opinion leaders. The UEA is a dynamic organisation which has recently experienced a considerable growth and development.

1.6 Salaries and wages in social services

The proportion of employment in the social services sector among member states is different, ranging from a mere one percent in Romania to 11.4% in Denmark. An above-average proportion of employment in social services exists in addition to the Scandinavian countries (Denmark, Finland, Sweden) also in the Netherlands, Belgium, France, Luxembourg, Ireland, and Germany. At the other end of the range are mostly new member states and southern countries (see graph 1).

Employees in social services (particularly caregivers) have been underpaid for a long time. In

Graph 1: Share of the social services workforce in relation to total workforce 2020 in the EU-27



Source: Eurostat Labour Force Survey, employment 15 years and over in the social services sector (NACE 87 and 88) as share of total employment (all NACE codes)

2017, the unemployment rate in the Czech Republic declined to 2.9% (ILO measurement), being the lowest in the EU. It was difficult to acquire skilled as well as non-skilled workers. The demand for jobs was caused by an increase of wages in the private sector. At that time, the average gross monthly salary of a caregiver was EUR 750.

In May 2017, supermarkets started to advertise wages of EUR 1,000 for warehouse operator and sales clerk job positions and workers in the social services sector started to leave. This caused the reduction of capacities in social services.

On this point, we have defined together with unions the following goals:

- Increasing salaries in the public sector (which has a subsequent effect in the private sector).
- Releasing sufficient funds for social services to cover higher costs (for public as well as private providers).

To achieve these goals, systematic pressure was exerted on the government from all possible sides, which included specifically: a joint letter to the minister of labour and social affairs, joint activity of employers and unions, opening the topic at tripartite meetings, organisation of press conferences, approaching individual parliament members, regions and municipalities. The result was that in 2017 the basic salary increased by 33% for caregivers, by 19.4% for technical staff, managers and administrative staff, and by 10% for nurses in social services (a lower increase than for the other positions due to the 10% increase in the previous year). This stopped the departure of caregivers from social services.

Caregivers 2017–2021

- EUR 750 GROSS per month

Caregivers 2021

- EUR 1.250 GROSS per month
- + 66% in 5 years
- Caregivers in home care and day care – 11%
- Caregivers in the private sector – 8–10%

Costs of living – ALL costs per

- 3 rooms + separate kitchen, 75m2 – EUR 588
- 2 rooms + separate kitchen, 60m2 – EUR 470

2. The Netherlands

2.1 The Dutch system of providing care

The concept behind the Dutch health care system stems from more or less universal principles, which include: access to care for everybody, solidarity through health insurance (which is obligatory and available for all) and a high quality of health care. The Dutch system was necessarily formed by a whole series of historical trends, developments and social conditions.

2.1.1 A brief history of long-term care in the Netherlands

Before 1960

Prior to 1960, long-term care concerned primarily patients with chronic illnesses, persons with mental or physical disability and senior citizens. Long-term care was financed by a combination of a high excess, public and charity contributions and the act on insurance of senior citizens and persons with disabilities. This complex and considerably overburdened system was not only obsolete, but first and foremost it did not meet the standards of quality and dignity.

Building the welfare state

During the welfare state building period, there was a general consensus on the need to reform the health care and long-term care system, consisting of:

1. a complex system of sickness insurance in the case of a disability and an insurance for uninsurable persons or high-risk persons;
2. the Dutch Long-term Care Act (Awbz) has brought a solution for the extremely high burdening due to chronic illnesses and disabilities, which may happen to everybody;
3. based on the social principles, joint risks must be carried by the entire population.

Years 2000 to 2014

During the period from 2000 to 2014 the long-term care system collapsed, primarily for these reasons:

1. the risks of insurable care were transferred to the Awbz,
2. the long-term care system was very generous,
3. ageing population.

The solution for the collapsing system of long-term care was to return to the fundamentals. The health care reform took place from 2004 to 2015. As the first step for the solution of the collapsing system, a new Long-term Care Act is drawn up (Wlz, replacing the Awbz), which only applies to persons suffering from a chronic illness, a mental and/or a physical disability. At the same time, the Social Support Act (Wmo) covering home care and supportive care is introduced. Another step was to transfer the risks of insurable care onto the basic and supplementary

health insurance, which is regulated by the Health Insurance Act (Zvw).

2.1.2 Foundations of the current health care system after reforms

The Dutch health care system is governed by four basic acts: Act on Health Care (Zorgverzekeringswet), Act on Long-term Care (Wet langdurige zorg), Act on Social Support (Wet maatschappelijke ondersteuning), and Act on Youth (Jeugdwet). In addition, there is also a whole range of general acts (including the Competitiveness Act/Mededingingswet) and several specific acts regarding health care (such as the Act on Quality of Care Institutions). These four acts on health care constitute the foundations of the Dutch health care system (see table 1).

The Health Insurance Act (regulating care in hospitals) and the Long-term Care Act (targeted on different types of care) cover most of the Dutch health care budget. The Long-term Care Act is a national act regulating health care in the whole of the Netherlands. In the implementation of the Health Insurance Act, private health insurance companies perform a key role in a system which is based on "regulated competition" and a number of specific public requirements.

The Social Support Act and the Youth Act provide for other forms of care and support. Some 400 municipalities in the Netherlands bear the primary responsibility for the enforcement of these two acts.

2.1.2.1 Principles of the Dutch health care system

The current Dutch system of health care is best described by a series of recent changes. In 2006, a new Health Insurance Act entered into force, according to which the citizens of the Netherlands are entitled to a basic health insurance package. This act is implemented by private, competitive health insurance companies and health care providers. It has to be noted that almost all health insurance companies in the Netherlands are non-profit cooperatives, using all their profits for the creation of mandatory reserves or refunding them in the form of a lower premium. In the Netherlands, there are in total 24 insurers, who are liable for their operations.

The Health Insurance Act has transformed the Dutch health care system from a supply-based system into a demand-based system. Private health insurance companies improve the health care system in several ways: a shorter waiting period and simpler bureaucracy in combinati-

Health Insurance Act	Long-term Care Act	Social Support Act	Youth Act
▪ Health care ▪ Private insurance	▪ Long-term care (24 hours a day) ▪ Public insurance	▪ Support of self-sufficient living in home environment and social inclusion ▪ Provided by municipality	▪ Handling of developmental, parental and psychological issues and disorders ▪ Child protection ▪ Provided by municipality
Private	Public	Municipality	

Table 1: Four acts of Dutch health care system

on with a stronger emphasis on efficiency and quality in the interests of patients and insurers. The process of selective formation of contracts allows health insurance companies to control the efficiency and the quality of the care provided by individual providers. Also, the public has a certain degree of control over this process thanks to the possibility to change the health care provider every year and may influence the policies of health insurance companies and health care institutions. Even though the health care system is basically private, the government performs a control function with the objective to protect public interests.

2.1.2.2 Long-term care, health services for youth and health support

The Act on Long-term Care, the Act on Social Support and the Act on Youth have been introduced recently and their current versions have entered into force in 2015. Based on a mandate of the central government, the Long-term Care Act is applied by special long-term care administrators. There are several other organisations involved in its implementation, such as the Centraal Indicatiestelling Zorg (Care Assessment Agency) and the Centraal Administratie Kantoor (Central Administration Office). Local authorities are responsible for the implementation of the Social Support Act and the Youth Act – they provide support, assistance and services and in so doing, they are supported by health care providers.

These acts are motivated by the opportunity to improve the quality of the provided care, to promote an integrated approach and ensure accessible and affordable health care also during the era of ageing population, in which many people suffer from chronic illnesses. This system focuses on opportunities rather than on people's insufficiencies. At the beginning, people are encouraged to seek support in their own social communities and from their own resources, but there is always support available to those who are not able to find it by themselves. Those who require constant supervision or non-stop home care are entitled to the services under the Long-term Care Act. The health care system has been revised to enable the adoption of these three new acts.

In the first step of this process, the General Act on Exceptional Medical Expenses was repealed. This act covered a wide range of care and support services, which gave rise to the risk that the long-term care system would become uncontrollable. Some of the persons who used the services under this act now fall under the Health Insurance Act, the Social Support Act or the Youth Act. Since 2015, all long-term care has been provided under the Long-term Care Act, which is intended strictly for the most vulnerable groups of people.

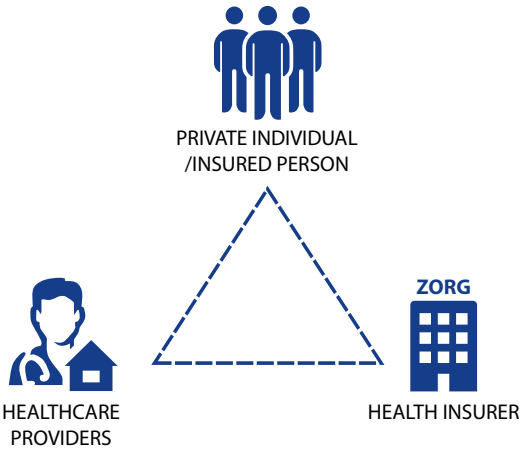
Local authorities continue to be responsible for the administration and implementation of the Social Care Act and the Youth Act. Many people who formerly were covered by the General Act on Exceptional Medical Expenses may now apply to local governments for lighter forms of care and support. This change is motivated by the fact that local authorities are closer to people and therefore are able to provide more efficient care in higher quality.

2.1.2.3 The four acts in practice

Private individuals are affected by the four acts regulating health care in ways described below. For example, when somebody needs to visit

their GP or is hospitalised, the costs are covered from the obligatory basic health insurance package under the Health Insurance Act. Those who need constant supervision or a 24-hour home care use the provisions of the Long-term Care Act.

The Social Support Act and the Youth Act provide for other forms of support, assistance and care. For example, those who need home assistance or are in a wheelchair due to an illness may ask local authorities for this care. These authorities may procure care under the Social Support Act. When families need, for example, parental support or their autistic child needs support in activities of everyday life, local authorities may procure this support under the Youth Act. This is to illustrate the health care and support service provided under the four health care related acts.



2.1.3 Health Insurance Act

Medical care in the Netherlands is provided under the single Health Insurance Act, which has replaced a series of separate public and private types of health insurance in 2006. About 60% of the total health care budget is reserved for services provided under the Health Care Act.

Public and private

The Dutch health insurance system combines elements of a public and a private insurance. The central government is directly involved in the implementation of the Health Insurance Act and defines a number of public requirements which guarantee the social nature of the health insurance:

- private individuals have the obligation to purchase the basic health insurance and may choose their insurance company;
- health insurance companies have the obligation to insure these private individuals regardless of their health condition;
- the insurance premium is the same for all the insured, regardless of their health condition, age or origin;
- health insurance companies have the obligation to provide care: they must ensure that the health care in the basic package is available to all the insured;
- the content of the basic health insurance package is defined by law.

The central government is not directly involved in the actual implementation of the Health Insurance Act, specific procedures are defined by health care providers, health insurance companies and the insured parties. This structure gives health care providers sufficient freedom, while competition and market forces stimulate effectiveness and high level of quality.

2.1.3.1 Basic health insurance package

What does the Dutch basic health insurance package include? The central government determines the content and the size of the statutory health insurance package which is available to all people in the Netherlands. On this matter, the government consults an independent office re-

sponsible for the basic health insurance package, the Zorginstituut Nederland (the National Health Care Institution). The government then decides which types of care will be included in the package and when this care should be provided.

The basic health care package has a comprehensive structure and includes a range of indispensable health care, medicines, and treatment aids, which satisfy modern needs and medical practice. The package also includes a certain volume of physiotherapy and dental care.

The basic health care package contains the following types of care:

- medical care provided by general practitioners, medical specialists (consulting physicians) and obstetricians;
- district nursing;
- hospitalisation;
- mental health services, including hospital care (in connection with mental health) for the maximum of three years;
- medication;
- dental care up to 18 years of age;
- services provided by various therapists, including physiotherapy, remedial therapy, speech therapy, and occupational therapy;
- nutrition/dietary care;
- medical aids;
- use of an ambulance/medical transport in sitting position;
- physiotherapy for persons with chronic illnesses.

Within the framework of the open government defined package, health insurance companies are free to decide within the defined parameters, who will provide the care and where the care will be provided. This is done through careful negotiation and formation of selected contracts on the basis of a large bulk of (anonymised) data which are accessible to health insurance companies and which describe the quality, efficiency and client experience. Health insurance companies have the obligation to provide care: they must ensure that the services included in the basic package are available to all their insured. Aside from the obligatory basic health insurance package, health insurers offer supplementary insurance for additional care, which is used by some 90% of the Dutch population. This includes, for example, a special dental policy, alternative medicine/homeopathy, glasses and contact lenses, and a more generous coverage of physiotherapy, maternal care and medication. Private individuals are free to choose whether they wish to take on a supplementary policy, and if yes, whether they wish to use the service of the same insurer that provides them with the basic health insurance package. The supplementary insurance is in its nature entirely private and as such is not regulated by governmental rules.

2.1.3.2 Ensuring the quality of health insurance

The main parties acting under the Health Insurance Act are private individuals, health insurance companies and health care providers. All the three groups play a key role in relation to the quality of the provided health care and the health insurance. Firstly, there are the actual users: they have the possibility to change the health care provider and each year choose the better (or cheaper) insurance company. In this respect, by switching to a provider offering services with a higher quality they have a chance to choose the best care. These dynamics ensure that the nine health insurance companies operating on the Dutch market must compete for their clients. In

addition, people may influence the behaviour of health insurance companies through various representation bodies. If they are dissatisfied with the implementation of the Health Insurance Act or with the services provided, they may connect with some of the number of independent organisations. Then there are health insurance companies: they control the quality and efficiency of the care they purchase. If the quality of the care is inadequate, they may decide, based on the large volume of information to which they have access, not to sign a contract. If the health care budget is fixed, health insurance companies are motivated to pursue efficiency in their service purchase policy.

Health insurance companies also ensure that the reports sent to the health care providers are accurate and check whether the reported care has actually been provided and that the given process is efficient. Health insurance companies also have the obligation to provide care, which includes, among other things, assistance with the search for a health care provider, if necessary. Finally, there are health care providers, who determine how the care is provided. Health insurance companies have quality standards which determine what may be decided in an operating theatre or a consulting room.

2.1.4 Ensuring health care

All the citizens of the Netherlands are entitled to the basic health insurance package, but what steps do they have to take to receive the care? Except for urgent cases, the procedure under the Health Insurance Act is the following. A general practitioner refers a patient to a medical specialist and acts as an "intermediary" of such applications. If it turns out that an application is necessary, the referring practitioner decides together with the patient on the necessity of the care and treatment. In the next step, the insured person selects a service from the available health services, and a health insurance company gives advice and support only in the necessary cases. The health care provider selected by the patient discusses with the patient the options of the treatment and provides them the required health care.

2.1.4.1 Funding health care under the Health Insurance Act

Under the Health Insurance Act, all insured persons jointly contribute to the total costs of the care as a whole. There are two major financial flows.

1. All insured persons over 18 years of age pay the "nominal" advances to their health insurance company. These advances amount to around EUR 1,509 annually (2022). In addition, all individuals over 18 years of age have the obligation to pay an additional amount of EUR 385 (amount for 2022); the reason is to increase public awareness of health care costs. Various forms of health care (including care by general practitioners and maternal care) are exempted from this regulation. For children and youth under 18 years of age, the health insurance costs are covered by the government from public sources.

2. There is an income-dependent contribution which is paid by employers. At the macro level, this contribution constitutes an amount comparable to the annual advances. The income-dependent contribution falls within the Health Insurance Fund together with the government's contribution for children and youth up to 18 years of age. For some types of care in the basic health insurance package, persons have the obli-

gation to pay excess in addition to the additional contribution. Excess is used to cover items such as transportation of a patient, hearing aids, specific medicine and orthopaedic shoes. Individuals may voluntarily decide to increase the additional contribution to the maximum of EUR 885, which reduces their nominal advances.

Under the Health Insurance Act, persons with a low income are entitled to a health insurance allowance, which is provided by the Tax and Customs Authority (the Dutch revenue authorities). This allowance may cover a substantial part of the premium together with the additional contribution. On average, persons with the lowest income pay less than they would pay in the system before the reform. This means that health insurance companies are paid from the nominal advances and the sources of the Health Insurance Fund, which happens through risk adjustment.

Health insurance companies receive a "risk adjustment contribution" from the Health Insurance Fund. Depending on the health condition of its clients/insured persons, a health insurance company receives a lower or higher contribution from the Health Insurance Fund. The reasons for this are linked to the defined public requirements mentioned above. Without risk adjustment, fair conditions could not be achieved because the position of the individual insurance companies would be more or less advantageous depending on the level of the covered risk. Risk adjustment is designed to prevent health insurance companies to select patients based on their risk levels. If they purchase the basic health insurance package, Dutch citizens may choose from various types of insurance policies: there is a policy with contractual or non-contractual health care. Under a policy with contractual care, insurance companies only provide complete coverage for those health care providers with whom they have signed a contract, in other cases the insured cover part of the costs themselves.

Under a policy with non-contractual care, insured persons may choose their own health care provider and the insurance covers all the costs of the care. Approximately four quarters of the Dutch population have some form of a policy with contractual care. There are also cases when a health insurance company does not cover the costs incurred: this applies to treatment costs not covered by the basic health insurance package (e.g. aspirin or specific forms of cosmetic interventions) and not covered by the purchase of a supplementary insurance (e.g. root canal cleaning by a dentist).

2.1.5 Long-term Care Act

Dutch citizens who need constant supervision or a 24-hour home care use the provisions of the Long-term Care Act. This act regulating health care has entered into force on 1 January 2015, replacing the General Act on Exceptional Medical Expenses.

2.1.5.1 Solidarity

The Long-term Care Act applies to a lower number of persons than the former General Act on Exceptional Medical Expenses (Awbz): it includes the most vulnerable population groups such as senior citizens in advanced stages of dementia, people with a serious physical or mental disability and people with long-term psychiatric disorders. The Centrum Indicatiestelling Zorg (Care Assessment Agency) assesses the special needs of these persons based on a standardised national format. Clients whose need for special

care have been assessed may use care at home, in a nursing home or a similar facility. Based on a mandate of the central government, the Long-term Care Act is applied by special long-term care administrators. These administrators have transferred the actual implementation onto the health care administration offices, which are located in each region and are closely linked to health insurance companies. The manage the manner in which health care services are provided.

The Long-term Care Act defines a health insurance based on the solidarity principle: anyone who pays an income tax in the Netherlands pays advances under this Act.

2.1.5.2 Quality

Clients and their representatives, the central government, the Care Assessment Agency, the Dutch Health Care Authority, the health care administration offices, and health care providers are the main stakeholders under the Long-term Care Act who jointly determine the quality of the Act and the relevant health care services and initiate the increase of the quality of the provided care. When clients are not satisfied with the provided care, they have the option to choose some other contractual health care provider. Individuals who are the recipients of health care based on the "personal health care budget" may also choose their health care provider and the required quality of the purchased care services. They also have the option to file a complaint with health care providers, the health care administration offices and the Health Care Inspectorate. The health care administration offices may define quality requirements for the purchase of care under the Long-term Care Act. Also, they may check whether the reports submitted by health insurance companies correspond to the care provided and comply with the signed production contracts.

2.1.5.3 Care under the Long-term Care Act

Serious and intensive care to which the Dutch population is entitled under the Long-term Care Act is described by a number of widely defined functions. This provides substantial freedom in organising the care, which is designed jointly together with the health care provider. The most frequent functions are:

- **a stay in a care facility:** a long-term stay or placement in a nursing home or a determined protected housing for mentally disabled;
- **personal care:** assistance with body washing, dressing, toileting, feeding, and drinking;
- **self-sufficiency support:** assistance in preparation of a daily plan, increasing control over one's own life, teaching basic household tasks;
- **nursing:** medical aid such as treatment of wounds or injection administration;
- **treatment under the Long-term Care Act:** treatment, non-medical care, or behavioural therapy which contribute to healing or improvement of a specific issue;
- **transport from/to a daily programme or daily treatment:** for persons whose health condition prevents them from travelling alone to their daily programme or daily treatment. The central government together with the National Health Care Institution decide what types of care will be included in the health care package under the Long-term Care Act.

2.1.5.4 Availability of health care

Persons who demand the most serious and most intensive care may contact the Care Assessment Agency, which will determine what type of care an individual needs, this is called "diagnosis". In the next step, the Care Assessment Agency informs an independent health care administration office; there are 31 of these offices in the entire Netherlands. A health care administration office manages long-term care based on a specific needs assessment, made by the Care Assessment Agency, then discusses the situation with the client (e.g. the person requiring medical care), who may ask for a particular health care provider. Has a client chosen to stay in a nursing home or in an assisted/protected housing or does he or she prefer living in their own home, where such option exists? One also has to consider in what manner the care will be provided. This may take place on the basis of a contractual relationship, for example where a health care administrative office provides care purchased from specific health care providers. Care may also be arranged through a personal health care budget, when people themselves purchase and arrange for the care.

Clients and health care providers subsequently prepare a health care plan (in the case of contractual care) or a budget plan (for personal care), while the health care administration office informs the health care provider about what care the client requires. A health care provider subsequently provides the care according to the prescribed health care plan or budget plan.

2.1.5.5 Funding health care under the Long-term Care Act

The Long-term Care Act stipulates statutory social insurance for everybody who pays advances in the form of an income tax. The amount of an advance for the social insurance premium is determined as a fixed percentage (9.65%) of the income tax and must not exceed the defined maximum of EUR 35,129. In addition, adults who wish to use the health care services under the Long-term Care Act pay a personal contribution the amount of which varies with their income. In this case there is a difference whether a client lives in a place of their own, or in a care facility, whether they are younger or older than 65 years, and whether they are single, married or live with a spouse.

All contributions are collected in the Long-term Care Fund, administered by the National Health Care Institution. If the financial means in the fund are insufficient, they are supplemented from public sources by the central government. Various forms of funding are used, depending on whether a client has chosen contractual care or a personal health care budget:

- in the **case of costs for contract-based care**, part of the funds is transferred to the Central Administration Office (CAO). The CAO subsequently provides payments to health care providers on the basis of a mandate of health care administration offices.
- In case of **payments from a personal health care budget**, part of the funds is transferred to the Social Insurance Bank (Sociale Verzekeringsbank/SVB), which manages personal budgets for persons using them. Those who are responsible for organising health care on the basis of a personal health care budget are entitled to use funds from the Social Insurance Bank. Invoices of health care providers (up to the maximum amount) are subsequently sent to the Social Insurance Bank, which pays them.

2.1.5.6 Supervision over the functioning of the system of care

In the Netherlands, responsibility for the supervision over the proper functioning of the health care system rests with the central government.

The central government defined the quality requirements which providers must satisfy under the Long-term Care Act. There are also other government authorities responsible for the supervision. One of these government authorities is the Consumer and Market Protection Office, which performs supervision over the competition in the health care sector. This office ensures that the conditions in the health care sector are advantageous for persons dependent on the care under the Long-term Care Act. Another government authority responsible for the supervision over the health care system is the Dutch Health Care Authority, which ensures that health care is provided efficiently and in compliance with the prescribed rules. Finally, the last government authority performing supervision is the Dutch Health Care Inspectorate, which supervises the quality and safety of the health care provided under the Long-term Care Act.

2.1.6 Social Support Act

Under the Social Support Act from 2015, the responsibility for the provision of support to persons with a disability has been transferred onto local authorities; this applies to persons with a physical, mental or psychological disability, including persons with learning disorders, and the elderly. The support is designed to ensure that these persons may function as productive members of the society and to allow them to live in their own households. In addition, under the Social Support Act local authorities provide for protected housing and support to persons who do not have other options or those who cannot live on their own.

Self-governing approach: personalised care and inclusion

The Social Support Act is based on personalised solutions and individual approach. Local authorities discuss the application for care with the client. Subsequently, it is up to the local authority to provide a suitable type of support and determine how this support will be arranged. Based on individual needs, local authorities have the obligation to provide general support to those who need it. The objective of this provision is to ensure that all people regardless of their disability may live as active members of the society: this is the foundation of an inclusive society.

2.1.6.1 Support under the Social Support Act

Under the Social Support Act, local authorities support persons who have difficulties to be socially involved, are not able to take care of themselves, or need protected housing, or other form of support, including, but not limited to:

- assistance and daily programme/activities;
- support in household;
- support in the form of informal care;
- volunteering;
- a place in a protected housing for persons with long-term psychological disorders;
- support for men, women and children who are victims of domestic violence;
- social support to homeless persons;
- financial support to those who have considerable additional expenses due to a chronic illness or health issues.

When providing support under the Social Support Act, local authorities distinguish between general and personalised services. General services apply to the society as a whole: this may include, for example, "coffee mornings" in a local community centre, buses to transport senior citizens to shops, a "meals on wheels" service, or discounted or free-of-charge transport for all persons above 75 years of age. Personalised services are meant for individuals and may include, for example, assistance and support in the household (cleaning and arranging), support in keeping personal records, or an agreement involving several types of support.

2.1.6.2 Ensuring support

Persons who need support to be able to go on living in their home and be actively socially involved may contact a local authority or be referred to the local authority or a local community group by a general practitioner or some other service provider. Many local authorities have set up local community groups as a contact point in their municipality and as providers of lighter forms of support. The first necessary step is registration. After registration, a meeting is scheduled with the person applying for support and the local authority considers what the clients are able to ensure for themselves with the help of their close persons or with the use of general services. The applicant must answer questions concerning the factors relevant for the local authority's decision, such as: a debt, social exclusion, or confusion. Based on this information, the local authority makes a recommendation, which is noted down in the resultant report. A possible conclusion may be that a client is able to obtain support for themselves with the help of their close persons or can cope with the general services or is in need of personalised care.

When an application for personalised services is submitted, the local authority decides whether the application for support will be approved or dismissed. Personalised support may be provided in two different ways:

- on the basis of an agreement, when the support is provided and procured by the local authority itself;
- on the basis of client's wishes, when the client may receive a personal health care budget to finance his or her own purchases of support.

A client may be asked to pay a personal contribution for the personalised care.

2.2 Social dialogue

In the Netherlands, there is the effort to achieve consensus about the objectives and means of social and economic policy through a dialogue of various parties. These talks take place at several different levels. At the company level, the Work Council negotiates with the management. At the sectoral level, trade unions negotiate with employer organisations the collective conditions of their employment. At this level, collective employment contracts are formed, which regulate the wages, the benefits and the working conditions for 470,000 employees working in care facilities, nursing homes and home care in the Netherlands. These contracts have the status of an act, which means that employers in the elderly care sector must comply with them, which ensures fair conditions for everyone. Topical issues dealt with in collective employment contracts are the following.

1. **Employees first** – the goal is to reduce the workload, give employees more space to express their opinion on and influence the wor-

king hours, rosters, education and other issues. Due to the demographic developments (population ageing) and budget reduction the workload has increased. There is the same number of employees working in the care sector as in 2012, but the number of clients demanding care has increased by 23%. Currently, clients are not entitled to care unless they have reached a higher age or unless their illness progresses to a more serious phase.

2. **Compensations and benefits** – the goal in this case is to reduce the differences in the incomes in the care sector and the rest of the market, allowance to working from home, transport allowance. With regard to the fact that in the Netherlands care is financed from public sources, the annual budget for compensations and benefits is determined by the Ministry of Health. A study of salaries and other benefits has shown a 9% gap between salaries in the care sector and those in the other market sectors. The government has decided to increase the budget to mitigate this gap.

3. **Technical issues** – with finding a job, ensuring compliance with collective employment contracts, harmonisation of multiple agreements, etc.

Negotiations at the national level take place both within the Social and Economic Council (SEC) as well as the Work Foundation (Stichting van de Arbeid). All of these talks constitute part of the Dutch "consultative economics".

2.2.1 Social and Economic Council (SER)

The SER consists of the representatives of employer and employee organisations and several members of the royal family nominated by the government. Together, they advise the Dutch government and parliament on social and economic issues and perform a number of administrative tasks. In addition, the SER has to obligation to motivate individual sectors to take into account public interests. In connection with this task, the SER supervises the compliance with merger rules and self-regulation in consumer matters.

The SER is an independent chief advisory body of the Dutch government and parliament on social and economic matters. Upon request or of its own initiative, the SER gives advice to the government and the parliament on the formation of the social and economic policies. Thanks to that, the SER consists of experts from among scholars as well as practitioners and may draw on the vast expertise in this field. Thus the SER may advise on issues that influence many Dutch citizens, such as jobs, income, social security, taxes, professional education, land use planning, and the environment. The Dutch consultative economics has three levels.

1. **Company level** – there are the work councils, which offer consultations on important economic and organisational matters. In addition, it approves issues connected with employment, such as working hours, health and safety, etc.

2. **Sectoral/company level** – at this level, there are 500 collective employment contracts covering roughly 80% of employees at the sectoral level and 20% of employees at the company level.

3. **National level** – this is where the Work Foundation and the Social and Economic Council operate.

Activities performed by the SER:

- **Discussion platform, agenda setting:** Organisation of discussions, inclusion of social partners and wider groups into the issues of the relevant policies, sharing of ideas;
- **Advisory role:** Giving advice to the government and the parliament on the formation of the social and economic policies;
- **Self-regulation:** coordination and implementation of common matters, such as consumer rights, code of conduct during mergers; international corporate social responsibility (CSR);
- **Implementation of specific acts:** predominantly where such acts directly affect the social partners (e.g. the work council).

2.3 Employment and education

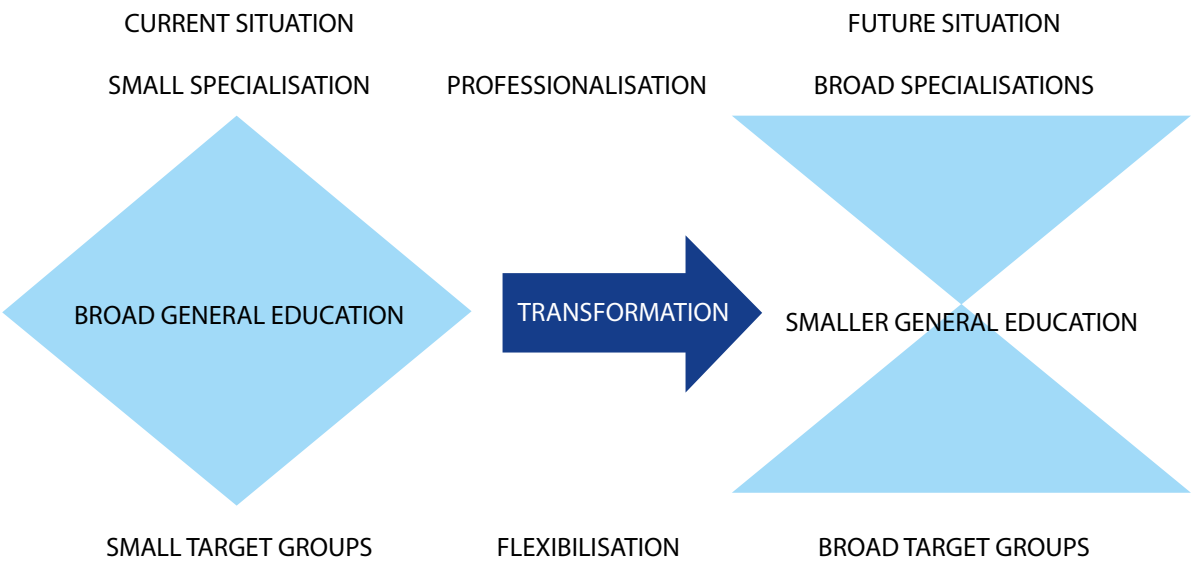
The basic function of the ActiZ is to be an employer organisation and serve the interests of its members in the domain of provision of care. The roles of an employer also involve policies relating to education, and skills and qualifications of the workers in the care sector. The major trends include professionalisation and a higher flexibility of the workforce in long-term care. As regards increasing flexibility, the ActiZ has introduced the Nationale Zorgklas. Together with educational software developers in the care sector, the ActiZ has created two short (4-day) training programmes directly focusing on the skills necessary to support health care workers during the crisis. These training programmes took place on-line and were offered by over 30 schools across the country. All volunteers could enrol in these trainings without any additional costs through the website at www.nationalezorgklas.nl. Volunteers were divided in groups and trained in the course of several weeks. A labour market crisis set in, caused by the Covid-19 disease. At the start of the crisis, it was necessary to focus on several domains/topics:

- Preparation for a major expansion of health care: e.g. social centres or sports facilities with accommodation.
- New thinking about the labour market: what do we do when there is a major shortage of professional staff in the care sector?
- Strategy: Professional staff in the care sector will work in a more comprehensive setting to create space for new staff in a less comprehensive environment.
- Founding the national initiative "Additional helping hands": with the primary aim to connect new workers in the care sector with regional organisations.

During the crisis, it was necessary to cope with several challenges in education of workers in the care sector.

- In the Netherlands, education in the care sector is a regional/local responsibility.
- Completing the common educational programmes in the care sector mostly takes two to three years.
- Academies offering education were overburdened with modifying/adapting the ordinary educational programmes to the digital/on-line form.
- The knowledge about Covid-19 was completely new for the academies providing education in the care sector.
- Even though (local) emergency programmes were developed, there was no national coverage.
- On-line education was considered too superficial, impersonal and inaccessible.

Scheme 1: A transformation in long term care education



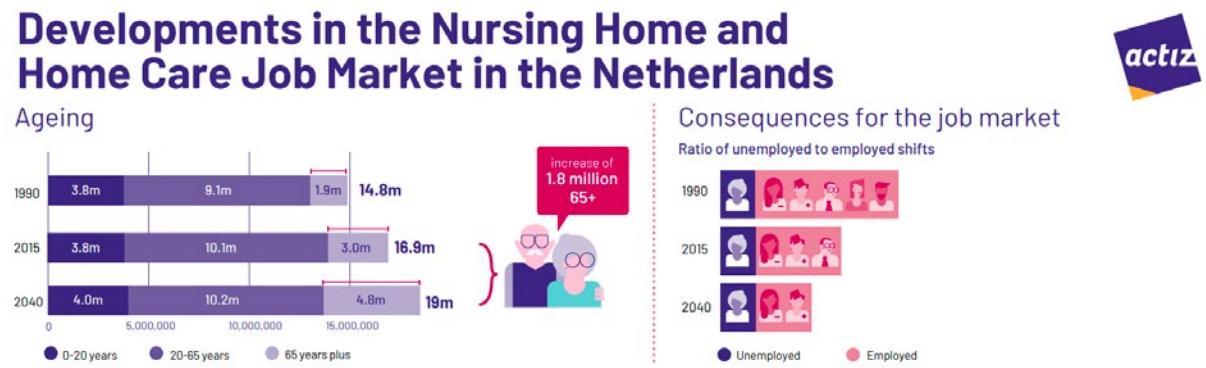
The solution for the challenges relating to the Covid-19 crisis was the national education in care, when the national digital platform for education of workers in the care sector was created. To ensure the quality of the provided on-line education, the participants also had access to on-line individual lessons with professional teachers. In this area, collaboration was also established with local schools and other educational institutions. Another important step was the raising of the political and financial support from the Dutch Ministry of Health, Social Affairs and Sports and the launch of an initiative in the form of a non-profit organisation including representatives of trade unions, employers and schools offering education in the care sector (see scheme 1).

2.4 Big data

The ActiZ wants to serve the interests of its members as best as possible and act as a trustworthy and reliable partner. It operates on the basis of facts and science, not on the basis of opinions and speculations. Thus the ActiZ is a data subject (Kijk op Data) where the clerks of the economic reporting units derive meaningful information from (bulk) data. For example, the measurement of employee satisfaction or (during the Covid crisis) provision of data on infections and other medical data to the government.

2.5 Public debate

In our ageing society, we are going to struggle with a serious lack of workforce. The following picture clearly shows the development of the 65+ age group. The numbers of these persons in the society are constantly growing. It is estimated that in 2040 the number of persons in the 65+ age group will be 4.8 million. This constitutes a growth of almost 2 million compared to 2015. This of course impacts the labour market because the numbers of economically active population decline, which reduces the proportion between economically active persons and the 65+ age group (see scheme 2).



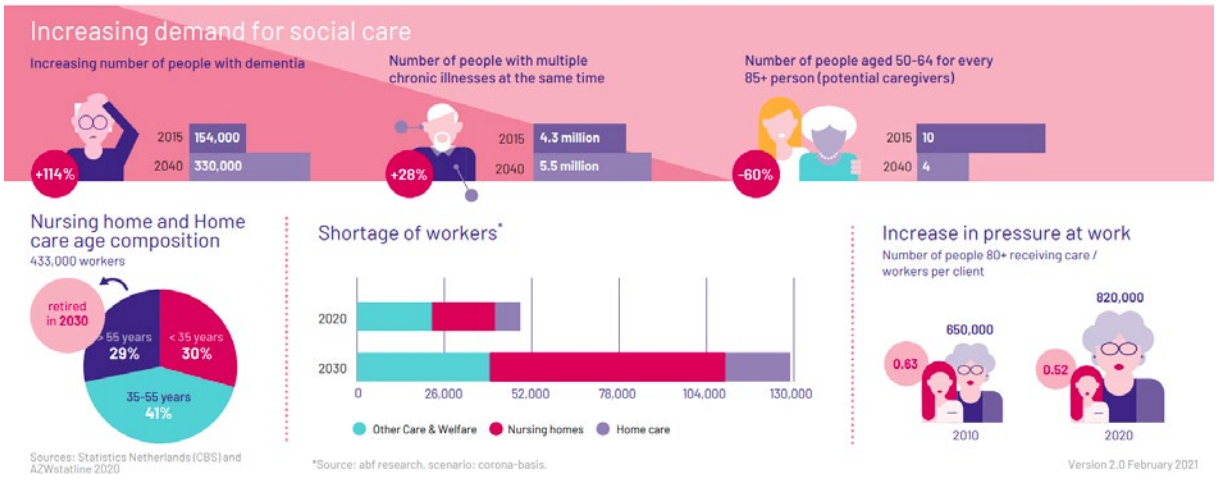
Scheme 2: Developments in the Nursing Home and Home Care Job Market in the Netherlands

Related to this is also the fast growing demand for social care. In the care sector, we estimate by 2040 the growth of the numbers of people with dementia to 114% compared to 2015. Also increasing will be the numbers of people suffering from chronic illnesses. There is also the decline of the numbers of potential employees in the care sector per one person above 85 years of age. In 2040, this proportion will be lower by 60% than in 2015. The consequence is the increasing pressure not only on employees in the care sector, but also on the entire sector, which must face challenges coming along with the ageing of the population (see scheme 3).

The paradox is that while the demand for certain things needed to keep the system running constantly grows, they become less and less available. Just like the climate, ageing is a social issue that is very important both for the young as well as the old. Society must make a fundamental decision regarding the manner in which care will be arranged.

Doing nothing is not an option. Care for the elderly requires continual innovation, we have to be the pioneers and the society as such must pay more attention to this agenda. The ActiZ organisation's role is to open and stimulate discussion on the future of long-term care and to promote and support innovation.

The Dutch design foundation asks two questions. The first is what new products and services



Scheme 3: Increasing demand for social care

helping the elderly to live active life in a society based on inter-generational support (including young people) have become a standard and how can we promote mutual assistance? The second question is: What if there were types of housing in a municipality/city/self-governed unit where people of all ages could live their lives without problems, move and receive care and support and what would such housing look like and what requirements would have to be satisfied?

3. Finland

Finland is a country with a population of 5.55 million. Finland is a member state of the European Union (EU) and with its area it is the fifth largest country in the EU. Persons in the 75+ age group make up 9.1% of the population.

Finland is divided into self-governed municipalities (there are 295 of them on Finland's mainland). The official languages include Finnish (88% of the population), Swedish, and Saami.

The per capita GDP, measured by the purchasing power parity, amounts to EUR 32,700, varying slightly above the EU average. In Finland, there are 15.7% of the population at risk of poverty or social exclusion. Unemployment as of 2021 amounted to 7.7% and in 2022 it is expected to decline to 7.0%.

3.1 The Finnish social assistance and health care system

The Finnish constitution stipulates that public authorities are responsible for the provision of health care and social care services and their task is to promote health and well-being of citizens. Each citizen has access to high quality health and social services regardless of their financial situation.

Local authorities (currently municipalities, but from 2023 it is going to be 22 self-governed districts for provision of the services) are responsible for the organisation of social and health services. Municipalities may set up joint local bodies for the provision of these services. But they also may outsource the provision of social and health services to other municipalities or private service providers. The provided services are mostly public, supplemented with private providers and non-governmental organisations.

Social assistance includes social services and thereto related supportive services, as well as other measures taken by the persons employed in this sector to support and maintain functional capacities, social welfare and security, and the inclusion of individuals, families, and communities.

Health services are classified into primary, secondary and tertiary care. Primary care is provided by 142 local health care centres, secondary care is provided by 20 central hospitals and some local hospitals, tertiary care is provided in five university hospitals, which are owned by municipalities. Services provided by public hospitals are supplemented with services provided by private hospitals. There are less than 10 private hospitals in Finland. Employers have the obligation to procure preventive health care

for their employees and a majority of employers voluntarily procure additional health care.

The social and health care sector employs some 400,000 persons. A quarter of them are employed in private health and social services and non-governmental organisations. Compared to the EU average, Finland has a lower number of medical doctors per person, but a higher number of nurses. Nurses play an important role in the health and primary care, covering more than half of all visits. Approximately 60% of medical doctors have a medical specialisation. In most cases in social services, certified social workers (social workers, workers in social services, workers in care for the elderly, and rehabilitation workers) bear responsibility for the establishment and maintenance of relationships with clients. However, there is a whole range of other professions involved in the provision of social services. In most of Finland's regions, there is a considerable shortage of medical doctors and social workers.

3.1.1 Funding and expenditures

Social services and health care are funded from local taxes and contributions by the central government. Municipalities may also charge fees to service users. The Finnish Social Security Office (Kela) covers a part of the expenses of private physicians, including dentists, and some other health care expenditures.

In 2017, the Finland's health care expenses amounted to EUR 20.6 billion, which corresponds to 9.2% of GDP, which is a bit less than in the other Scandinavian countries.

3.1.2 Information technologies and ICT

In digital and electronic services Finland is among the leaders. Patient health data and prescription information are collected by the national Kanta data bank. Through this system, health care workers can access patient data, archive medical records and issue prescriptions. In addition, patients may inspect their own medical records and prescriptions. Recently, also the social services data have been transferred into the Kanta system.

3.1.3 Management and supervisions

The Ministry of Health and Social Affairs manages and develops social care and health services and the functioning of the entire sector. Together with the government and the parliament, the Ministry is responsible for the articulation of the national policy in social and health care. The Ministry also prepares legislation and key reforms in the social and health care domain. Regional state administration bodies are responsible for the supervision over the social and health services in the individual regions. The national supervisory body for social services and health care (Valvira) is responsible for the supervision over the social and health services in the entire country.

3.1.4 Reform

In Finland, the need for a reform of health and social services has been discussed for more than ten years. A generally accepted goal is to reduce inequalities in the welfare and the health of the population and improve the equality of access to quality services.

From 2023, the health and social services reform will transfer the responsibility for the arrangement for health and social services to self-governed regions (districts) consisting of territorial units larger than municipalities.

3.2 Social services

The Ministry of Health and Social Affairs is responsible for Finland's social policy and prepares legislation in the area of social care.

Social assistance includes social services and thereto related supportive services, as well as other measures taken by the persons employed in this sector to support and maintain functional capacities, social welfare and security, and the inclusion of individuals, families, and communities.

3.2.1 Social services provided by municipalities

In urgent cases, people are entitled to social services in the municipality in which they are located at a given moment, with view to their individual needs and in a manner that does not jeopardise their right to the existential minimum and care.

In all other cases people are entitled to the social services at their place of residence. Municipalities must provide for the following services:

- self-care and self-sufficiency support;
- housing support;
- financial support;
- social exclusion prevention and support of inclusion;
- responding to needs in the consequence of interpersonal relations and domestic violence or other forms of violence and abuse;
- responding to the needs for support in an acute crisis;
- ensuring balanced development and welfare for children;
- responding to needs in the consequence of alcohol or drug use, mental issues or other illnesses, disabilities, or old age;
- responding to the need for support in connection with reduced physical, mental, social, or cognitive functions;
- support to the families and friends of those in need.

Whether a given service is necessary is assessed individually for each service. Everybody is entitled to the assessment of the need for a service, unless it is apparent that such assessment is unnecessary. The assessment of the need for a service must begin immediately and be finished without undue delay. Urgent services must be provided for immediately. Social service clients are also entitled to their own worker.

Private social care

Social services provided by private companies and organisations are supplementary to the local services. A municipality or a joint local body may also purchase services from private service providers. Approximately one third of the social services are provided by private companies or organisations from another sector.

3.2.2 Social services under the Social Care Act

General social services under the Social Care Act include:

- Social work and social counselling
- Social rehabilitation
- Work with families
- Home services and care

- Informal care
- Housing services
- Institutional services
- Services to support mobility
- Services to support mental health and persons using addictive substances
- Child guidance and family counselling
- Supervision during contact between parents and children

Local social services provided under special legislation include, but are not limited to, social services for persons with disabilities, special care services for persons with intellectual disorders, additional and preventive social care, child protection, rehabilitation occupational activities, mediation of contact in the areas of child foster care and right of access, family work, and support of informal care.

Due to a large volume of the services and the relevant legislation, services are often combined in the following groups depending on the life cycle model: services for families with children, services for adults and services for the elderly, despite the fact that all stem from the same legislation; and more specifically:

1. Services for families with children, including, but not limited to: home services, work with families, child guidance and family counselling.
2. Social services for the elderly, including, but not limited to: home services, informal care support, services to support mobility, and institutional care.
3. The needs of persons with disabilities are covered primarily by the general health and social services and where these services are insufficient, a decision is made on the entitlement to special services.

3.2.2.1 Health and social care reform

The organisation of Finland's health and social services and rescue services will be reformed. In 2023, the responsibility for the arrangement of these services will be transferred from municipalities to districts for the provision of services. The main goal of this reform is to improve the availability and the quality of the basic public services in the entire Finland. The reform will create on Finland's territory 21 self-governed districts for the provision of services. In addition, the city of Helsinki will be responsible for the provision of health, social and rescue services on its own territory.

The private sector is dissatisfied with this reform because it reduces the role and the importance of the private sector even though usually it provides high quality social services in a more efficient manner than the public sector.

3.3 Social dialogue and collective bargaining in Finland

Collective bargaining concerns most of employees in Finland and until recently it was mostly a centralised process resulting in a national agreement defining the framework for the increase of salaries at the lowest levels. In recent years, collective bargaining has finally moved to the level of the individual sectors, which created more space for negotiations at the company level.

For more than 40 years, collective bargaining in Finland took place at three levels: the national level, the sectoral level and the company level. Bargaining at the national level (general regulation of incomes) included the entire economy and usually provided recommendations

for the parties bargaining at the sectoral level, which recommendations were subsequently put into practice, allowing for certain improvements at the company level. Often, the government played the key role in these national negotiations, for example by changing taxes or the social security based on the results of these negotiations. In spite of that, this system was not always successful and there was no statutory duty to negotiate in this way. From 1968 to 2006 national negotiations were the basis for determining salaries.

In 2007, when the private sector employers' association (EK) refused to negotiate the new arrangements at the national level, this system has crashed. At that time, employers insisted that the talks take place at the sectoral level and take into account sectoral specifics. In May 2008 the EK, the main employers' association, issued new directives stipulating that in future they would not return to the negotiations on salaries at the national level. In reality, however, the association played a key role in the national level negotiations in some periods even after this decision.

The results of these negotiations included a two-year framework agreement, which was signed in October 2011 in response to the economic crisis, a three-year agreement on employment and growth from 2013, which was also signed in the period of economic trouble in Finland, and a one-year agreement on competitiveness signed in February 2016 in response to the government's intention to reduce public spending and increase taxes. All these agreements followed the traditional pattern including governmental measures and in general have returned to trade union concessions on salaries and to negotiations between confederations of national trade unions and the main employers' association. Since the expiry of the competitiveness agreement in 2017, subsequent negotiations have returned to the sectoral level and have not been continued at the national level.

Whether the overall rate of salary increases is determined at the national level or by individual sectors, it is in the sectoral level agreements where the tariffs and the basic conditions are laid down. These tariffs and conditions apply to the employers who are members of the employer associations which have signed a given agreement and there is also a mechanism which extends the validity of the agreement on all employees in a given sector. Since 2001, this process has involved an independent commission which formally decides whether a given agreement will be generally binding on all employers (and employees) in a sector. This decision primarily depends on whether a given agreement covers more than half of the employees in a given sector (this is calculated from the numbers of employees of the association members who have signed a given agreement) or whether it is broadly anchored in a different way. Disputes regarding the decisions of this commission may be submitted to the labour court.

Collective agreements in social services define the minimum reward for work, salaries, working hours, leave and other parameters for all workers in the sector. Those who work for municipalities are covered by this agreement in the public sector, while workers in third sector private companies and organisations are covered by the agreements negotiated by the HALI for this sector with trade unions.

The number of employees to whom collective bargaining applies has grown in the private sector and national companies from 75.5% (only for the employers who are members of the associations which signed the agreement) to 84.3% (including employers covered by the generally the binding agreements).

Because collective bargaining applies to all the employees of the central government and the municipalities, the total number of the employees covered by collective bargaining reaches almost 90%.

Beneath the sectoral level there is the company level bargaining, which has gained significance in recent years and which in general happens through agreements at the sectoral level rather than in the form of separate agreements. These arrangements may improve the conditions of the sectoral level agreements as well as cover other changes. Employers have pressed for a higher flexibility at the company level and in some cases their requirements were granted. For example, a whole series of agreements in 2018 and 2019, including the key agreements covering 100,000 persons in technological industries, allowed for the increase to be negotiated at the local level.

3.3.1 Levels of bargaining

When bargaining takes place at the national level, it concerns agreements between the confederations of national unions and national employers' associations, primarily the EK. Bargaining at the sectoral level takes place between the trade unions and the business associations in a given sector. Usually, agreements are negotiated by the representatives of the individual confederations separately.

The negotiations usually resulted in conditions which were valid for two and a half years to three years. This is not firmly stipulated and since 2009 the agreements have been signed for shorter periods. For example, the agreement on competitiveness signed in 2016 remained valid for one year only. Agreements signed from 2017 to 2018 were mostly valid for two or three years and it is possible that this form will come back in future.

During the last two years, negotiations have moved a step closer to collective agreements at the company level. The Finnish wood processing industry has refused entirely to negotiate collective agreements at the sectoral level. The largest exporter of technological industry has partially taken the same direction. Trade unions are not satisfied with this development and are concerned about their role. Other employer organisations, such as the HALI, continue to bargain collective agreements at the sectoral level, with the aim to gain a more important role at the level of local companies.

3.3.2 Subject-matter of discussion

Agreements at the sectoral and company levels define salaries and working conditions and in some cases also concern wider issues.

In Finland, there is no system determining a minimum salary at the national level. However, applicable to most employees are the tariffs determined in the collective agreements regulating a given sector because their employer is a member of an employers' association which has signed the agreement or because a given agreement is, due to the validity expansion process, binding on all employers in a given sector. For those who are not covered by any agreement,

the Act on Employment Contracts stipulates that employees must be paid a "standard and reasonable salary".

3.4 Working conditions and environment for workers in social services

Suitable working conditions must create a safe and friendly environment which poses no threat to health. This promotes good and motivating management, good climate at the workplace and professional performance by employees. It also influences work performance. Good workplace conditions increase the productivity and work effort and reduce the number of sick leaves, promote enthusiasm at work, motivation and employee initiative. Therefore they are directly linked to productivity, competitiveness and the reputation of a given employer organisation.

Both employers and employees are involved in the creation of the right working conditions. Employers must ensure the safety of the workplace, good management and fair treatment of their employees.

Employees play a key role in the preservation of their work and professional skills. Each employee has the chance to contribute to a good climate at the workplace. Work satisfaction may be enhanced by the development of working conditions and skills.

A topic currently discussed in Finland is an excessively heavy workload in the social care sector and the dissatisfaction coming along with it. These arguments are presented mostly by nurses' unions. According to independent surveys, the situation is not that bad but all the parties agree that in social services the pressure on the workforce increases due to the development of the demographic factors. The population of Finland ages, which means a higher need for social services and a lower number of persons in a productive age.

3.4.1 Salaries

Minimum requirements of collective agreements in the private social sector for remuneration for work:

The minimum salary as of 1 September 2021 outside the region of the capital city (in the region of the capital the minimum salary is higher by 1.4%):

- assistant € 1,807 – 2,008/month
- caregiver € 2,060 – 2,273/month
- nurse € 2,322 – 2,583/month

An average monthly salary with compensations for night and weekend work, Autumn 2020:

- assistant € 2,153/month
- caregiver € 2,623/month
- nurse € 2,862/month

Usual number of hours worked per week:
38 hours 20 minutes

Minimum annual leave 4 weeks in the first year:

- 5 weeks after the first year
- 6.5 weeks after 15 years of work experience

On average, the rewards in the public social sector are better. This is primarily due to the difficult financial situation in the private social sector. Most services are purchased by municipalities and the price they pay to private sector suppliers is typically by 30% lower than their own expenses for the same services.

3.4.2 Activities and projects aiming at making the social care sector more attractive

Currently, there is a live public and political debate going on, regarding the possible solutions for the growing demand for workers in the care sector.

The main suggestions by employer organisations include:

- Opening more study positions at all levels of education in the health and social sector.
- Easing the strict qualification requirements for working in social services (all workers do not need the three-year education for nurses).
- Simplifying the recruitment of foreign workers from non-EU countries and recognising foreign education more often than is currently the case.
- Naturally good quality of work and a sufficient level of remuneration are also important, but it is necessary to accept limited financial means because most of the funding comes from the public sector.

The main suggestions by employee organisations include:

- Significant increase of salaries in the care sector and improvement of working conditions.

3.5 Qualification and education

Care in social services is provided primarily by workers with a three-year special training (caregivers). Some employees have a higher education degree as nurses, which education takes 3.5 years. A lower number of employees work as assistants who do not have specialised education or have a one-year education for care assistants.

Nurse

- 3.5 years, Bachelor's degree in social and health care.
- Students learn to provide high quality care and ensure the safety of patients, perform various nursing interventions, and work in a multi-professional team in a simulated environment and in practical situations, while studying social and health care.

Caregiver

- 2.5 – 3 years, specialised education in social and health care.
- A caregiver works as a member of a team consisting of multiple professions in care and nursing, education, rehabilitation, or client services.
- A caregiver is an interacting and responsive service oriented professional.
- Common basic education is completed within the first two years of the studies.
- The last year of the studies focus on the specialised competences in the chosen field.
- The programme also includes practical training.

The practical training takes several months. Students acquire a deeper understanding of what the actual work in the field is like and the workplace benefits from student's work. This practical training is not a regular employment and during this period students are not entitled to any salary.

3.5.1 Structure of education in the field of social and health care

With the progressing change of the population structure, the numbers of old people will in future be a big challenge for the social and health sector. Due to technological changes, also the structure of and the work procedures in health services face new challenges. Social and health programmes may be studied at many levels of education.

The offer of education in the social sector is wide. Social and health care may be studied at universities, technical schools, secondary and vocational schools. Social work students may complete their studies for example as child caregivers, local nurses or sociologists. Social work may also be studied at a vocational school or a university of applied sciences. University programmes include qualifications such as a social worker.

Social work is a professional activity focused on helping people and communities. The same expression may be used for social sciences research and university education in social sciences. Social workers are required to have the qualifications prescribed by law, which may be achieved by completing a Master's programme in social work.

Graduates of higher education in social care work specialised jobs in nursing homes, children's homes, kindergartens, schools, in health services, facilities for mentally disabled, in family counselling, with drug addicts, perform rehabilitation works, and project and organisational works. The work of university graduates in social programmes is demanding, specialised and responsible in relation to clients and is regulated by many laws and regulations, directives and guidelines.

The social status of a given work together with the relevant duties and work targets of each organisation determines the specific requirements for a given position. Works demanding a wide range of skills have a fundamental influence on the lives and life conditions of individuals.

3.5.1.1 Social and health care at vocational schools

At vocational schools, one can study in the Bachelor's social and health care programme, upon the completion of which one acquires the qualification as a local nurse. There are various study specialisations, such as working with the disabled, pedicure, care for and rehabilitation of the elderly, or nursing and care. The Bachelor's degree in social and health care is granted to professionals of community care working at responsible positions. Nursing jobs require reliable skills, determination to serve and a sense of responsibility.

3.5.1.2 Social and health care at universities

In Finland, social work may be studied at six universities. The goal of social workers' efforts is to increase the involvement of people and communities, provide services, prevent occurrence of issues, find solutions, assess and monitor situations, decide, and bring up ignored issues. Social workers work specialised jobs in offices, nursing homes, children's homes, kindergartens, schools, in health services, facilities for mentally disabled, in family counselling, with drug addicts, perform rehabilitation works, and project and organisational works.

3.5.1.3 Social and health care at technical schools

Graduates of social and health care programmes include: Nurses, midwives, rehabilitations workers, professional therapists, physiotherapists, and sociologists. Graduates from a degree programme in nursing in the English language are entitled to a Bachelor's degree in health care. All these degrees may be followed by studies in Master's degree programmes. The basic education at technical schools is equivalent to secondary or vocational education and the corresponding foreign degrees. Applicants for studies at technical schools within the framework of education of adults must, in addition, have two years of practice and be older than 18 years of age.

4. Experience
from visits to institutions and facilities plus examples of good practice

4.1 Czech Republic

The first study trip within the project was arranged in the Czech Republic. The trip took place in February 2019 and the participants were the representatives of the Hyvinvointiala HALI ry association (Finland) and the Dutch ActiZ association. The representatives of both the associations were guests of the APSS CR, which associates 1,241 organisations providing over 2,700 registered services (situation as of 25 January 2022).

On the first day of the study trip, the visitors were made familiar with the Social system in the Czech Republic and the system of education of workers in social services. The presentation of the Czech Social System also included the presentation of the care allowance. From the information obtained, the participants concluded that a care allowance may be one of the tools which can offset or relieve the pressure exerted on professional care.

The participants were also informed about the APSS CR' activities and could make themselves familiar with some of them in more detail in workshops. The first of these workshops focused on the course Certified manager in social services. It is a unique accredited educational course for managers in social services, who acquire the education in five basic areas: a legal minimum, economics, managerial skills, strategic management, and HR management. The participants appreciated the comprehensiveness of the entire course, including HR management and staff management through modern methods for building and motivating a successful team of employees. In another workshop, the study trip participants had the opportunity to try out the Virtual reality – dementia application, which gives one the chance to see the world through the eyes of a person with dementia. The attendees at this workshop evaluated very highly this

Introducing of Virtual reality – Dementia

first-hand experience which provides better understanding of what a person with dementia goes through. The participants were of the opinion that it would be desirable to mediate this experience not only to workers in social services, but also the family members or students.

On the second day of the programme, there was a meeting scheduled with the deputy mayor of the town of Tábor, who spoke aboutWhat Tábor does for social services. Thus the study trip participants had the opportunity to gain information on how investments in social services are made and planned, also in connection with the staffing of social services. The specialised programme on the third day of the study trip included a meeting with the representatives of the Office of the Government of the Czech Republic and the Ministry of Labour and Social Affairs of the Czech Republic. The representatives of both the institutions spoke about the Social dialogue in the Czech Republic and the Role of the state in social services and social dialogue. The participants agreed that a well-defined immigration policy of the state may help to overcome the lack of workers in social services, particularly with regard to the predicted ageing of the society.

Meeting with the representatives of the Office of the Government of the Czech Republic

The afternoon of the third day of the programme focused on the Social dialogue in the Czech Republic from trade union's perspective and the presentation of the Union of Employers' Associations as a social partner. Participants learned, among other information, that in social dialogue partners have an advisory role also in the planning and establishing social care facilities. As regards staffing of social services, the main problem is funding. The salaries of the employees in social services make up as much as 73% of the total budget costs annually. The participants mentioned that firstly it is necessary to set the same salary conditions for private and public providers of social services. Their opinion was that without equal conditions there was no adequate solution for the issues of funding. The manner in which employee conditions are negotiated is different in different countries. During negotiations, one also needs to take into account the difference between the numbers of the hours

Visit and excursion of home for elderly and day care centre, G-centrum Tábor

Visit and excursion of home for elderly, Domov pro seniory Bechyně

usually worked in individual countries. In the Czech Republic and Finland, the usual practice is to work full-time, while in the Netherlands part-time work is commonplace.

4.1.1 Basic School and Kindergarten and Provider of Social Services, Kaňka o.p.s.

Basic School and Kindergarten and Provider of Social Services, Kaňka o.p.s.

Centrum Kaňka has existed from 2002 and provides social services of Personal Assistance, Early Care, and Day-care Centre, and pre-school and school education to children, youth, and adults with disabilities. All these activities are linked and interconnected. The pillars of the care are 7 therapies, which are regularly used by clients, whether on stay-in or outpatient basis. The centre uses the principles of multidisciplinary care, focuses on working with the entire family.

Examples of good practice:

- **Day-care centre reconstruction** - Moving the service into new and newly reconstructed and equipped spaces within the premises will for the near future provide capacity for a group of the current Kaňka special school students with moderate and severe combined disability who will continue to be the clients of the day-care centre after completion of the school. The purchase of modern equipment will also change the working environment for the day-care centre workers and increase user comfort.
- **Care for employees** has been one of the facility's priorities for many years now. Centrum Kaňka supports further education and personal development of employees, emphasising the use of modern aids and equipment in their work. Additional benefits include allowance for commuting, catering, work clothing, regular teambuilding events, and a system of regular feedback interviews. Also, an intensive programme of regular group supervisions and the possibility of individual consultations with a supervisor have for several years now become a common instrument of care for employees.
- **Innovative approach to fund-raising** - A public benefit company operates on the basis of multiple sources of funding. A continuous maintenance of the high level of the services provided by qualified staff depends on active search for and use of all suitable and available sources: subsidies from state administration and self-governed bodies, project funding from endowment funds and European grants, collecting internal resources from direct user payments, public fund-raising campaigns to finance internal projects, long-term work with corporate and individual donors, organisation of public events with proceeds used to support the operation of the facility, work with volunteers, and other activities. Fund-raising is closely linked to the organisation's PR activities; the decision on creating one position for both the activities has proven to be effective. It is also thanks to these activities that the funding of the two above-mentioned examples of good practice, the day-care centre reconstruction and care for employees, was possible.

4.1.2 Home for the Elderly in Bechyně

Home for the Elderly in Bechyně

The Home for the Elderly in Bechyně is a contributory organisation of the South Bohemian Region. The facility provides a stay-in social service to 60+ senior citizens with reduced self-sufficiency caused by age and health condition whose individual needs can no longer be met by their families or field or outpatient social services. The service is provided in a new comfortably furnished home with single and double rooms with the maximum capacity of 122 clients. All services are provided on individual basis, with view to the actual needs of individual clients so as not to create dependence on the service. The facility's staff supports its clients in self-sufficiency, getting involved in and being active in everyday life. They respect their right to make their own decisions concerning themselves and their life. Considering the life story of the clients, they try to build an environment where clients will feel at home – safe and satisfied. The main motto of the home is: "With love, reverence and respect we will stand by you..."

Examples of good practice:

- **E-Qalin®** – a European quality management system focusing specially on homes for the elderly. This system is oriented on all target groups, which include users, family members, employees, the management, and the surrounding environment. This self-assessment system has helped in many respects to increase the quality of the provided service or the defined processes and rules of a service. The E-Qalin® system has facilitated a better collaboration among the individual sections of the provided service and has contributed to improving the communication among employees, and between employees and the management.
- **Biographical approach to care** – allows caregivers to provide individual care to clients. Employees collect information from client's life. This information changes the manner in which the staff approaches a given client and this knowledge about client's life facilitates care for their patients because the relevant employee has a better understanding of client's behaviour and helps them maintain the rituals which the client has followed for their entire life.
- **Namasté Care** – an approach which is absolutely indispensable in palliative care for clients in the terminal phase of life and for clients with a severe dementia syndrome. Its greatest strength is an intense social contact of a caregiver with a small group of clients, with 5 clients at the maximum, every day for the entire morning. This gives caregivers an opportunity to directly respond to client needs with the use of client's biography. At the same time, this approach gives the caregiver a feeling that their work is needed and also prevents burnout.
- **Proportion of caregivers among employees** – a typical composition of the staff for 60 clients is 19 caregivers, 1 social worker and 2 nurses. The proportion of caregivers among

employees in the Czech Republic is much higher than in Finland.

- **The use of specialised knowledge and skills of all workers, not only those in direct care** – increases the quality of the care, which brings the opportunity for improvement in client's health condition and in many cases the preservation or improvement of client's self-sufficiency. Direct care employees are supported in further educating themselves in their profession. Education applies to all the employees of the facility. Also the staff in the kitchen are educated, about issues such as the quality of the diet, expanding the offer of meals, monitoring the nutritional intake by clients. Laundry workers and cleaning staff are not left out either. All the education of employees leads to a higher comfort of the provided care and a higher satisfaction of clients.
- **Group and individual supervisions for all employees of the facility** – its primary significance for employees is supportive and educational, particularly in the emotional and relational aspects of the work with the clients. Regular supervisions prevent burnout and also increase the quality of the service provided to the clients. Also individual supervisions are available to employees, if needed.
- **Psychological support to immobile clients or those with reduced mobility** – the aim is to give these clients the chance to express through a psychologist without worries their opinion on the provided social services, just like mobile clients, who can use a letterbox service for these purposes.

4.1.3 G-centrum Tábor

G-centrum Tábor

The G-centrum Tábor was built between 1997 and 1998 by the town of Tábor. The G-centrum operates the total of 7 social services. In the programme, the participants were made more closely familiar with the functioning of two of these, the old people's home and the day-care centre. The capacity for the old people's home is 143 beds in single or double rooms. The service is based on these principles: individual approach, provision of professional services, respecting individuals and human rights and free decision-making. The day-care centre service is provided to the 50+ age group from 6.30 to 18.30 o'clock.

Examples of good practice:

- **Regular education of employees** – contributes to increase the competence of all employees. Therefore the G-centrum Tábor organises for their employees regular trainings and courses directly in the facility. Employees are also regularly sent to specialised trainings, internships and conferences. This facilitates transfer of experience, knowledge, know-how and practices from other facilities.
- **Specialised internships and education** – the facility offers specialised internships and traineeships to students of nursing and high-

er vocational schools and retraining courses for direct care workers. These activities focus, for example, on the expansion of knowledge in areas such as payments for nursing care, remuneration and salaries in social services, reporting of nursing care, promoting positive approach of employees in social services, as well as issues connected with the care for the facility's clients such as handling of clients, caring for clients with a skin defect, individual planning of provided services and other issues.

- **Volunteering** – collaboration with the Tábor Parish Charity in volunteering. Volunteering is beneficial not only to the facility and its clients but also to the volunteers.

4.1.4 SeneCura SeniorCentrum Klamovka

SeneCura SeniorCentrum Klamovka

The SeneCura SeniorCentrum Klamovka is a new and modern facility which opened in 2015. The facility provides stay-in social services with a capacity of 116 places. Great emphasis is placed on the care for senior citizens with the Alzheimer's disease or some other form of old age dementia. Because it is located in the centre of Prague, the facility can collaborate with the community centres, kindergartens and basic schools in its vicinity.

Examples of good practice:

- **Brand of quality in social services** – is an external certification for social service facilities from client perspective, nevertheless it is an appreciation of the daily work of employees. The certification is a motivation and inspiration for employees to strive for a higher quality of the care and services provided to their clients.

Awards of Brand of Quality in social services

- **Friendly work environment and sufficiency of work equipment** – not only in the complicated times of a pandemic, it is a common practice for the managing staff to be interested first and foremost in our clients, the operation of the home, as well as our employees. Direct care employees will not care for their clients with love and full commitment unless they see their managers do the same. The culture of the home reflects the culture of its managers.
- **Care for our employees** – every day drinks for free (juice, water with lemon and mint), fresh fruits, meals for CZK 30, selection from 2 meals. Regular supervision, 3 times a week services of a psychologist in the home. At least 8 educational events in a month right in the facility, benefits including Chinese massages in the home, vouchers for cultural and leisure activities, regular teambuilding events outside the home.

- **The Klamovka journal** – a space for articles and interviews with our employees, our clients with photographic documentation, presenting joint events in and outside the home.
- **Family day** – an event taking place in the home for our employees and their family members, barbecues, banquets, music, contests for children.
- **Anonymous employee satisfaction survey– through an independent agency** – an important indicator of employee satisfaction in individual areas and an important tool for the management.
- **International cuisine days** – each month on the ground floor of the home - chef's event for clients and employees. A banquet including the best and most typical cuisine and drinks of a particular country.

International cuisine days

4.1.5 Palata – Home for visually impaired

The house was built in 1893 and from 2003 to 2005 it has undergone reconstruction and an extensive completion. With its capacity of 125 beds, Palata provides comprehensive stay-in services to persons with visual impairment. The entire complex is barrier-free and uses spatial orientation elements to give clients utmost feeling of safety.

Palata – Home for visually impaired

Examples of good practice:

- **Corporate volunteering** – means the support of public benefit organisations by a company and its employees. A company invests the time of its employees and the financial resources to the given organisation. Volunteers from companies most frequently help with auxiliary works such as weeding, raking, cleaning the premises, minor repairs, moving smaller pieces of furniture, etc. The corporate volunteering platform is constantly growing and the home also starts to establish collaboration in areas of expert volunteering, primarily with IT experts.

Corporate volunteering

- **Individual volunteering** – When recruiting new volunteers, the home focuses primarily on secondary school students because thanks to volunteering they might decide for a career

in social services. A volunteering day always starts with a discussion about the provided service and a tour around the facility, demonstration of the compensation aids so that the volunteers know where and for whom they will work and to make themselves at least partially familiar with the disability that the clients of the home suffer from. Most frequent activities include direct contact with clients which can have the form of conversation, reading, taking them for a walk, etc.

- **Employee selection and care** – the home pays great attention and dedicates a lot of time to the selection of employees. Selection procedures have as a minimum two rounds and include test volunteer shifts and only then a final decision is made by both the parties. It is important to subsequently continue to show interest in the employees and appreciate their work also verbally. This also contributed to the reduction of employee turnover in recent years. Employees can use the benefits offered by the home, such as the recreation contribution, child recreation contribution, contribution to massages, supplementary pension insurance contribution, the MULTIsport card contribution and others. The home also supports its employees in education by offering regular supervisions and internal trainings.
- **Working conditions** – as prevention of the burnout syndrome and minimisation of employee turnover. The home monitors on long-term basis the volumes of the provided services and responds to their changes by adjusting the job position structure and employee numbers. The result is a low number of overtimes and a balanced workload.
- **Accommodation for employees provided by the employer** – may be one of the decisive factors in acquiring new and keeping existing employees.
- **Student internships** – for the students of partner schools. The home collaborates on long-term basis with schools focused on social and health care. It maintains regular communication with and attends the meetings organised by the schools. Schools are offered field trips and are invited for Open Days. Students who prove themselves during the internship are offered further collaboration in the form of a temporary job in the home. Students are always assigned to one employee who trains them and guides them through the internship. Together they assess the progress of the internship and interns are offered the option of volunteering. There are some 160 students as interns in the home annually.

4.2 The Netherlands

In October 2021, the second study trip took place for the representatives of the Finnish Hyvinvointiala HALI ry association and the Czech APSS CR to the Netherlands. The first day of the trip started at the Dutch ActiZ association, which associates some 385 organisations

Introducing of social and health care system

with more than 400,000 employees, who take care for over 2 million persons in long-term care.

The representatives of the ActiZ presented not only the activities of their organisation but also the social and health care system in the Netherlands. In the Netherlands, care is built on private, profit and non-profit providers, when neither the state nor municipalities are the providers of long-term care services. Long-term care is provided on insurance basis and its provision is regulated by four acts. The ActiZ is one of the important leaders in innovation in the given region, which is connected to developments in digitisation and working with "big data", which are used to obtain information about, for example, potential clients and the demand for care, to gain an overview of the labour market and benchmarking.

The demand for care and new employees is increasingly stronger, however, in the Netherlands, just like anywhere else, skilled workforce is scarce. The Netherlands has a well-developed tiered system of qualification requirements on long-term care workers, which may make the recruitment of new employees much more difficult. In contrast, in the Czech Republic an employee must complete 150 hours of specialised training, which creates an advantage of fast recruitment of new employees and their quick integration.

Another topic was the social dialogue and general negotiation of salaries and working conditions. In connection with this topic, we also visited on the first day of the trip the Social and Economic Council (SER), which is a platform for collective bargaining between employers and trade unions and at the same time is an (independent) advisory body to the government and the parliament on economic and social issues. Collective bargaining in the Netherlands takes place at several levels. In contrast to the Czech tripartite, the SER has its own headquarters and employees.

On the second and the third day of our trip, we visited several social care providers in the Netherlands.

Visit and excursion of home for elderly, Zorg- en Wooncentrum De Haven

Visit and excursion of home for elderly, Stichting rijnhoven

4.2.1 Zorg- en Wooncentrum De Haven

Zorg- en Wooncentrum De Haven

The facility provides care to persons with dementia or physical issues who maintain a very close contact with the municipality's community. Formerly, the home was open to the elderly only, but that changed with time and a part of the facility now operates as a nursing home. The premises, consisting of several buildings, also include an experiential garden, which is open to all clients regardless of their mental or physical condition. This is possible thanks to a system of modern technologies – clients own a "smart watch" (a sensor) which enables them to move freely around the premises. This approach is in line with the home's management policy which is based on the freedom of movement. This policy is also applied in daily activities to ensure that clients feel at home.

Examples of good practice:

- **Automated system for promotion of client self-sufficiency** – when each client has in their "smart watch" (a sensor) defined zones which give them freedom of movement around the premises. The watch is programmed to automatically open doors for clients in these zones. This watch also minimises the occurrence of conflicts among confused or disoriented clients with dementia in the case of intrusion into their personal space because it prevents unwanted mutual visits in rooms. The entire security system, however, requires the satisfaction of high technical requirements for software and operating staff. In summary, this automated system enables:
  - caregivers and other employees easier care for clients, who may move safely around the entire premises including the garden;
  - adjustment to achieve a more efficient use of resources;
  - sufficient supervision over clients and reasonable workload;
  - reduction of undesirable incidents.

4.2.2 Warande Bovenwegen

Warande Bovenwegen

The Warande Bovenwegen facility provides care to persons with physical and memory issues. It offers long-term and temporary accommodation as well geriatric rehabilitation and intensive care for people with dementia. Each client has his or her own room. In its client care, this facility also uses modern technologies which increase the safety of clients, while reducing the workload placed upon the staff.

Examples of good practice:

- **Motion sensors and a smart camera** – for monitoring clients' condition at night. The original system was based on the use of motion sensors only, which detected, for example, an increased motion activity during sleep, which however was interpreted by the staff as a fall even though the client only got up from the bed and went to the toilet. The management considered this method to be overly burdensome for the staff and inconvenient for clients. Therefore a "smart" monitoring camera was added, which gives the staff an overview of what is actually going on in the client's room and prevents misinterpretations of situations. This system, however, does not intrude upon client's privacy, because the monitoring is not continuous but happens only on the basis of software assessment of a current situation. In summary, this approach has the following benefits:
  - reduction in the numbers of employees on night shifts and, by way of extension, reduction of organisation's costs;
  - care is only provided to clients when it is really necessary, which reduces the workload of employees;
  - more time for the administration tasks connected with client care for employees on night shifts;
  - improved working conditions for employees
  - reduction of anxiety and behavioural issues in clients.

Another way to reduce costs is, in the facility management's opinion, to use digital incontinence aids with special sensors.

4.2.3 Stichting rijnhoven

Stichting rijnhoven

Stichting rijnhoven is a home for 174 senior citizens, who are placed either in separate rooms (if requiring a more intensive care) or in zones with a small number of clients. The focus of the care is on psychogeriatrics and the aim is to enable clients to remain self-sufficient to the highest possible degree. The facility is divided into several residential zones, each having a central day room, and social facilities.

Examples of good practice:

- **Personnel policy promoting self-organization** – the staff are divided into teams with 15 members, each team is responsible for an assigned number of clients, may bring innovative ideas on how to improve the provided care, the quality of client's life and their working conditions. Each team prepare their own work schedule; the management is only involved in this process if a conflict or dispute arises. Such system enabled the reduction of the number of middle management staff, increased flexibility, while enabling to balance professional and family life. However, over the years it has turned out that such management model is only suitable for somebody who emphasises self-reliance and independence. The self-organisation system has the following benefits:

- employees may implement their own ideas about how to improve the provided care, quality of life in the facility and their working conditions;
- employees are given more responsibility for their work;
- a lot of part-time jobs, which allows employees a higher flexibility of working hours and more space to balance their personal and professional life.

4.2.4 Cordaan

Cordan

Coordan is the Acute Geriatric Community Hospital in Amsterdam. The care focuses on the treatment of acute illnesses, complex geriatric examination, timely rehabilitation, or efficiency of the follow-up care. The estimated duration of hospitalisation is 14 days. One of the reasons, among others, for the development of an illness is the fact that clients often need prompt and comprehensive care which cannot be provided at their home environment (e.g. strokes). Important for these patients is the follow-up rehabilitation so that they can return to their home environment as soon as possible.

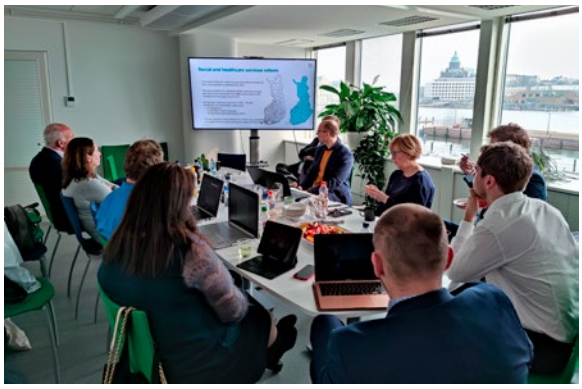
Examples of good practice:

- **Making geriatric care more attractive** – this project may be one of the ways to make geriatric care more attractive for nurses.
- **Cost savings** – the costs of hospitalisation are not that different, but this is not the case in relation to additional costs. Additional costs for care after leaving a community hospital are significantly lower than when a client leaves a hospital.

4.3 Finland

The last study trip to Finland was undertaken in March 2022. The trip was attended by representatives of the Czech association APSS CR, the Dutch association Actiz and the host organization Hyvinvointiala HALI ry (HALI). In Finland, HALI is involved in improving the environment for the provision of services in the social and health care sector and childcare. It joins together 1,500 members in this sector, employing more than 85,000 professionals. HALI is also involved in negotiating national collective agreements in these sectors.

On the first day of the study trip, the host organisation introduced us to not only the activities of their organization, but also the social and health system in Finland, which are linked very closely.



Introducing of the planned health and social care reform for 2023

Visit and excursion of home for elderly and day care centre, Kustaankartano Senior Centre

Visit and excursion of home for elderly and day care centre, Kustaankartano Senior Centre

The Finnish care system is highly integrated and unpillarized. In Finland, only one party arranges care, while in the Netherlands the care is arrange by three parties. Finnish municipalities are obligated to provide care for their citizens. It is their responsibility to decide whether to use public or private social care providers. Currently, the care is provided by 295 municipalities, which is causing inequalities between health and social care systems across regions. A health care reform planned for 2023 should be a solution to this issue because the number of municipalities will be reduced to 26. Reducing the number of municipalities should encourage equality between health and social care systems across regions. Although there are differences in arrangements of the care among partner countries, all countries have the same problems - they have to deal with an ageing society and the labour market problems that this entails. In Relation to the labour market, we discussed the topic of Qualification requirements for workers and rules of care in social services and its related topic Collective bargaining for private social service providers and the level of wages and other benefits. Within the context of wages and benefits, private providers are in a worse position than public providers. The reason is, municipalities that buy services pay private providers 30% lower costs for the same services than they provide themselves. Therefore, the financial situation in the private sector is very complicated and unsatisfactory. In the afternoon programme of the first day of the study trip, Finnish partners presented the JHL unions, their education system for social workers, and social dialogue at European Union level.

On the second and the third day of our specialised programme, we visited several social care providers in Finland.

4.3.1 Wilhelmiina Palvelut Ltd.

Wilhelmiina Palvelut Ltd.

Wilhelmiina Palvelut Ltd. provides care and rehabilitation services for the elderly. They are owned by the Miina Sillanpää Foundation. The structure of the non-profit organization allows you to use the profits of the organization to support and develop residential and other services for the elderly. The Wilhelmiina Residential

Services Centre opened in Pikku-Huopalahti, Helsinki, in 1995. Currently, the Wilhelmiina Centre offers accommodation, care and other services to approximately 160 elderlies. It has its own restaurant and cafe for its clients, which are also accessible to customers outside the centre. The rehabilitation unit, which is part of the centre, offers not only rehabilitation, but also temporary housing, e.g. for veterans, patients after surgery, housing for the elderly in home care during the holidays, and so on.

Examples of good practice:

- **Using of modern technologies to detect functional and cognitive disorders** – in cooperation with Benete Ltd., the Wilhelmiina Centre develops and puts into practice new technologies that are based on agile sensor technology and smart algorithms. They create a pattern of daily activities and habits of individuals. Through observation and analysis of these activities and habits it detects functional and cognitive disorders, helping Wilhelmiina Centre staff identify changes in health and well-being, so that they can focus on the acute needs of the clients. In addition, the BeneCare system helps the security of their clients. For example, the system will notify employee, when the frequency of using bathroom is lower than usual – this may indicate that client can need additional help. For residents with a high risk of falling, BeneCare allows caregivers to be informed based on residents‘ movements, and according to collective movement data, when a resident is about to get out of bed. This allows the caregiver to offer help and prevent a fall in time, for example at night.
- **Pathway of memory and training in the arts and business** – it represents the facility‘s efforts to support their clients and enable them to ’live the life they want to live‘. The training is part of the employees‘ training plan. This training, designed by their own memory disorder specialist, provides all Wilhelmiina Center staff basic information about memory disorders, and provides information about what is the best approach for their clients with memory disorders, and how to support them in their daily lives and independence. Also offered to employees training in the arts and business to support their organizational skills and teach them how to act and interact with clients, their relatives, and colleagues in teams, with a focus to find a solution. The coach of this training is certified in business (BCI) and a pioneer in arts and business coaching and theatre-based coaching.

4.3.2 Kustaankartano Senior Centre

Kustaankartano Senior Centre

Kustaankartano Senior Centre is a centre located in a beautiful park, and provides several social services for the elderly. In addition to accommodation services, the Kustaankartano centre also has a service centre and day care units. The daily activities of the facility are focused on providing simulation and rehabilitation activities for the elderly with mental diseases and with disabilities, or providing such an activities

that are intended primarily for the elderly with memory disorders. The goal of the day care units is to design activities so the elderly can live in their natural environment for as long as possible. The Kustaankartano Centre also has residential homes for the elderly who already need the 24 hours care of nursing staff. Residential houses also have common areas, where you will find cosy kitchens, spacious living rooms, rooms with fireplaces, and saunas.

Examples of good practice:

- **Use of leisure facilities for employees** – the Kustaankartano centre has leisure facilities that can also be used by its employees. For example, employees have a sauna, or gym at their disposal.
- **Further education of employees in palliative care** – which brings a new perspective on the care for dying person, and a new approach to the topic of dying and death. It is necessary to teach employees this philosophy and its procedures of care and support.
- **EPIC support system** – it is a software system also used by workers in the provision of health care. It is a central database with health information about the Finnish citizens. When a new client enters the facility, the staff has data from various health care organizations about their client, as well as this the health care facility has clear information about the health care provided by the social service facility. Thus this system enables the provision of quality care to the client, and also makes the work of medical staff in the facility easier and more efficient.

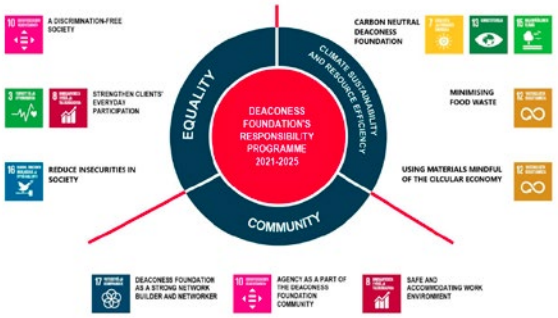
4.3.3 Deaconess Foundation

Deaconess Foundation

Deaconess Foundation is a non-profit organization with almost 155 years of history. The organization has 2,700 employees and over 1,000 volunteers who aim to provide a dignified life for all citizens. The Deaconess Foundation provides comprehensive social and health services not only to the elderly and people with dementia, but also cooperates with other organizations in the social care sector and provides opportunities to participate in community development and strengthen civic participation.

Examples of good practice:

- Responsibility as part of the strategy – the organization has a responsibility programme that includes specific and measurable steps for how to become even more responsible for the society, and the environment. This pro-



Responsibility programme

gramme is composed of three pillars: equality, community, and climate sustainability and resource efficiency. The programme is part of the organization's strategy and all employees participate in it, which ensures their participation and interest in the development not only of the organization, but of the entire community.

4.3.4 Folkhälsan

Folkhälsan

Folkhälsan is a non-profit organization that provides nursing care, home care, child care, youth counselling, and support for the disabled. The organization has more than 1,300 employees, and over 20,000 volunteers. The main goal of the organization is the quality of life and self-sufficiency of its clients. All services provided by Folkhälsan are focused on ensuring a high quality of life. Therefore, Folkhälsan provides a wide range of formal and informal services, such as saunas, wellness activities, and swimming pools. The organization also has its own research department, which is part of the international genetic research network.

Examples of good practice:

- **Lifelong learning and its evidence** – the staff of the facility are regularly trained not only in topics in the field of care, but also in the field of social sciences, language, and team leadership. The training of the staff is an important part of an organization's strategy, and lifelong learning and workflow reflection are seen as a continuous process that is one of the organization's key assets. All staff training is kept in an overall database which then facilitates the planning of further training and documentation of mandatory training during the inspection.
- **Employees as part of the community** – the goal of the organization is not to look at employees only as paid crew, but as full members of the community. When employees feel as if they are members of the Folkhälsan community, it increases the quality of provided care and leads to the retention of professionals in the facility, which is an important benefit in times of staff shortages. An example of being part of the community is the possibility to bring your pet to work.
- **Mediation of supervised professional internships** – social and health students can arrange professional internships in the facility. There is assigned a supervisor who accompanies the student through the daily work routine and interventions, and provides him or her with professional advice. The advantage of the student internships is the ability to offer him or her the full-time job in the future. The advantage for both parties is that a new employee hired this way already knows the working procedures of the facility, and adaptation to the new job is not so difficult.

Conclusion

We may generally conclude that the standard of social services in all the partner countries is very high, but that the approaches in the given countries are different. The Czech Republic is characterised by a high efficiency when comparing the quality of care and the funds allocated to the care sector. The Netherlands has a shortage of workforce, while having the highest proportion of volunteers in social services in the entire EU. In the Netherlands, volunteering is a natural part of life of all social classes in general. Finland must deal with a significant increase in the numbers of private care providers who "fight" for employees, it is therefore necessary to focus on all aspects of the working environment. At the same time, the HALI has a unique and very close relationship with trade unions and collective bargaining in Finland is at a very high level.

The collaboration among the partner associations, the APSS CR, the ActiZ and the HALI, was successful and will continue. Each organisation will make an electronic version of the collection accessible to its members, which will facilitate the transfer of good practices among social service providers. The organisations will also use its usual communication channels, including educational events, seminars, conferences, congresses and other events, to spread this collection.

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