ORIGAMI

Work Package 2 – Deliverable 1

SOCIO-ECONOMIC LITERATURE REVIEW REPORT ON CARE RE-GIME AT COUNTRY LEVEL

THE NETHERLANDS

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The care regime in the Netherlands.
How it shapes home care- and cleaning services

1. Introduction to the Dutch home care system

The Dutch care system is a hybrid model which combines public and private elements. Its goal is ensuring comprehensive care for all residents, and it operates on principles of universal coverage, solidarity, and high-quality care. It is funded primarily through mandatory health insurance, government subsidies, and private contributions. The system's regulatory framework aims to ensure the provision of accessible and efficient healthcare services, covering a broad range of medical and non-medical support options.

2. History and Evolution of the Home Care Sector in the Netherlands

The development of the home care sector in the Netherlands is closely linked with the evolution of its broader healthcare and social welfare systems. This section outlines the significant historical developments and legislative milestones that have shaped today's home care sector.

2.1. Early Developments

Early 20th Century : The early 1900s marked the beginning of organized healthcare and social services in the Netherlands. This period saw the establishment of social insurance schemes designed to provide financial support for health and welfare needs (Ministerie van Algemene zaken, 2021b).

1940s-1950s: Following World War II, the Netherlands, like many other European nations, began to develop a structured welfare state. The government introduced numerous social security programs to protect citizens from the economic risks associated with illness, old age, and unemployment. This era marked the initial steps towards formal home care services, although these remained limited in scope and coverage (Ministerie van Algemene zaken, 2021b).

1960s-1970s: This period saw significant expansion in public health and social services. A major milestone was the introduction of the General Act on Exceptional Medical Expenses (AWBZ) in 1968. The AWBZ provided a legal framework for funding long-term care, including home care services, for people with chronic illnesses, disabilities, and the elderly (Ministerie van Algemene zaken, 2021b).

2.2. The Rise of Home Care

1980s–1990s: The focus on deinstitutionalization grew during 1980s and 1990s, with policies aimed at enabling individuals to live independently in their own homes for as long as possible. This shift was driven by the desire to improve quality of life and reduce the costs associated with institutional care. Home care services expanded significantly as a result and were supported by public funding through the AWBZ (Ministerie van Algemene zaken, 2021b).
2000s: The introduction of the Social Support Act (WMO) in 2007 marked a significant shift in the Dutch home care landscape. The WMO decentralized the responsibility for home care and social support services to municipalities, emphasizing local governance and personalized care plans. This act aimed to enhance the autonomy and societal participation of individuals (Ministerie van Algemene zaken, 2021b).

2.3. Recent Developments

2010s: The 2015 reform of the long-term care system was another major turning point. The AWBZ was replaced by the Long-term Care Act (WLZ). The WLZ focuses on those with severe and chronic health issues, ensuring resources are directed to the most vulnerable. Home care and less intensive services were moved to the Health Insurance Act (ZVW) and Social Support Act (WMO), with local municipalities taking responsibility for these services. This decentralization allowed for more personalized and community-based care solutions. This reform aimed to streamline services, improve efficiency, and promote self-reliance among individuals (Ministerie van Algemene zaken, 2021b).
Present: Today, the Dutch home care sector is characterized by a mix of public and private provisions, with a strong emphasis on personalized care. Municipalities play a crucial role in organizing and funding home care services under the WMO, while health insurers cover medical home care under the ZVW. The sector continues to adapt to challenges such as aging populations, rising healthcare costs, and the need for integrated care solutions (Ministerie van Algemene zaken, 2021b).

3. Current legislative Framework and government regulation

3.1. Legislative framework

The Home Care sector today is affected by a legislative framework containing three important acts for this sector:

1) **Social Support Act (WMO)**: Introduced in 2007, this act decentralized the responsibility for social support, including non-medical home care, to municipalities. Its aim is promoting autonomy and participation in society (Ministerie van

Volksgezondheid, Welzijn en Sport, 2023a). Municipalities are tasked with assessing individual needs, providing tailored support services, and ensuring access to necessary resources and facilities for residents (Ministerie van Volksgezondheid, Welzijn en Sport, 2024a).

2) Health Insurance Act (ZVW) : Enacted in 2006, the ZVW mandates health insurance for all residents of the Netherlands and includes the covering of medical home care services (Ministerie van Volksgezondheid, Welzijn en Sport, 2023a). Here, the insurance companies take the responsibility of arranging care and associated tasks (Ministerie van Volksgezondheid, Welzijn en Sport, 2024a).
3) Long-term Care Act (WLZ) : Implemented in 2015, the WLZ focuses on institutional care for those with severe and chronic conditions, while home care services are managed under the WMO and ZVW (Ministerie van Volksgezondheid, Welzijn en Sport, 2023a). The tasks of care organization now fall under specialized care administration offices (Ministerie van Algemene Zaken, 2024a).

This legislative framework has shaped the Dutch home care sector into a complex, multifaceted system aimed at providing comprehensive support to individuals in need of care, balancing public provision and private initiative. By decentralizing social support to municipalities through the WMO, mandating health insurance for all residents under the ZVW, and focusing on severe long-term care needs with the WLZ, the framework ensures a robust network where responsibilities are clearly delineated. Municipalities assess and address non-medical support needs, health insurers cover medical home care, and institutional care is reserved for the most severe cases. This integrated approach allows for tailored care solutions, enhancing the quality of life for residents by fostering autonomy, participation, and accessibility (Ministerie van Algemene Zaken, 2021a; Ministerie van Volksgezondheid, Welzijn en Sport, 2023a).

3.2. Government regulation

At the national level, the Ministry of Health, Welfare, and Sport (VWS) is the primary governmental body responsible for public health, welfare, and sports policies in the Netherlands. The VWS oversees healthcare regulations, social welfare programs, and initiatives to promote sports and physical activity. Within the VWS, the Minister for Medical Care and Sport (MZS) focuses on matters related to medical care and health policy, ensuring healthcare accessibility, quality improvement, and collaboration with healthcare professionals. Additionally, the MZS promotes and develops sports initiatives to encourage physical activity among the population.

The State Secretary for Health, Welfare, and Sport (SVWS) assists the Minister by focusing on specific aspects of the ministry's portfolio, contributing to decision-making, policy development, and implementation. Both the MZS and the SVWS significantly influence the home care sector by shaping regulations. Their responsibilities include creating an environment that supports quality home care services and addressing challenges such as

workforce issues and healthcare standards. They also collaborate with relevant stakeholders, including home care organizations, to enhance the overall effectiveness and efficiency of home care services.

3.3. Regional and Local Governance

At the regional level, the Provincial States (PS) and municipalities play critical roles in coordinating and cooperating with regional healthcare services. While the PS primarily has a coordinating and budgeting function, municipalities are more actively involved in healthcare decision-making to better suit the unique demographic, cultural, and socioeconomic characteristics of their communities. Municipalities assess the home care needs of individuals, particularly those reliant on municipality budgets, and educate the public about their options, promoting health and well-being. The PS coordinates between municipalities in their region and advocates for the region's needs at the national level.

3.4. Independent Administrative Authorities

In addition to governmental bodies, independent administrative authorities (ZBOs) significantly influence policy decisions in the Netherlands. ZBOs are public organizations operating independently from the Dutch government, carrying out specific regulatory or administrative tasks autonomously. In the home care sector, influential ZBOs include the Healthcare Institute Nederland (ZIN) and the Dutch Healthcare Authority (NZa).
ZIN is responsible for promoting effective, accessible, and high-quality healthcare. It evaluates healthcare interventions, advises on the inclusion of treatments in the basic health insurance package, and supports the implementation of evidence-based care. ZIN influences the home care sector by assessing and advising on the inclusion of specific home care interventions in the national healthcare package, shaping policies related to the availability and funding of home care services.
The NZa regulates the healthcare sector in the Netherlands, ensuring fair competition, determining tariffs for healthcare services, and monitoring compliance with regulations to safeguard quality and accessibility. NZa's influence on the home care sector is significant, as it determines tariffs for home care services, regulates competition to maintain quality standards, and addresses issues related to accessibility. NZa's decisions impact funding, pricing, and the overall regulatory framework of home care services.

4. The organization of home care in the Netherlands

The ORIGAMI project defines home care as services provided in the context of clients their own homes. The project focuses specifically on cleaning services and long-term care provision. In the Netherlands, these types of services are organized by both the public and

private sector, each with distinct groups of workers, working conditions, and regulatory frameworks. The public sector, as defined by Statistics Netherlands, includes "nursing, personal, and household care provided in the home setting to chronically ill individuals, the elderly, disabled individuals, and those temporarily in need of such care" (Statistics Netherlands, 2024). This care requires a medical indication and involves trained nurses or healthcare specialists (Ministerie van Volksgezondheid, Welzijn en Sport, 2023). The private part of the home care sector is less defined and monitored. The International Labour Organization (2015) describes "domestic work" as "work performed in or for a household or households." This sub-sector has a high incidence of undeclared work and the most pressured working conditions (European Commission, 2015; 2021).

4.2 Informal Work in Home Care

It is essential to note that much of the home care work is informal. Estimates suggest that in Europe, the personal and household services sector has an undeclared work rate of 50%, reaching 70% in household employment (European Commission, 2021). Given the high acceptance of informal work in the Netherlands (WHO, 2012), these estimates likely reflect the Dutch home care sector.

4.3 Cleaning work

The formal part of the cleaning sector in the context of home care is regulated under the Social Support Act (WMO) (Ministerie van Algemene Zaken, 2021a; Ministerie van Volksgezondheid, Welzijn en Sport, 2023a). Non-medical assistance is provided, such as domestic cleaning and household maintenance, to those in need of such services due to medical reasons. No support is offered to those requiring those services without medical reasons behind it. The sector is marked by a high degree of undeclared work, with few companies offering at-home cleaning services but many individual workers do.

4.4 Long-term care work

Long-term care in the Netherlands covers services for individuals with chronic illnesses, disabilities, and the elderly, provided by both public and private sectors. Public services, mandated under the Long-term Care Act (WLZ), offer institutional care for severe cases, while less intense care is managed under the Social Support Act (WMO) and Health Insurance Act (ZVW) (Ministerie van Algemene Zaken, 2021a; Ministerie van Volksgezondheid, Welzijn en Sport, 2023a). The private sector, less regulated, involves informal work characterized by undeclared labor and pressured conditions. This system aims to provide comprehensive support while acknowledging the prevalence of informal work, ensuring accessibility and quality of care.

4.1. Funding of Home Care Services

The Dutch home care and cleaning services are funded through several policy instruments. The WLZ (Wet langdurige zorg or Long-term Care Act) is a mandatory public insurance scheme funded through income tax premiums, providing long-term intensive care for those with severe needs. The Care Needs Assessment Centre (CIZ) determines eligibility for this scheme (CIZ, n.d.; Ministerie van Algemene Zaken, 2021b). *Table 1* shows the amount of people with an indication of eligibility and the type of care they receive.
The WMO (Wet Maatschappelijke Ondersteuning or Social Support Act), managed by municipalities, covers social support and domestic help services, funded through local taxes and government grants (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). In *table 2*, the amount of people under this act and the type of care they receive can be found. The ZVW (Zorgverzekeringswet or Health Insurance Act) covers basic health insurance, including home medical care services, and is mandatory for all residents, funded through premiums and income-related contributions (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). In *table 3*, the amount of people under this act and form of care they receive can be found. Additionally, the Jeugdwet (Youth Act) provides services for younger disabled individuals and is managed by municipalities (Ministerie van Volksgezondheid, Welzijn en Sport, 2023a). Personal budgets (PGB) give recipients flexibility in managing their care funds directly (Ministerie van Algemene Zaken, 2024b).

4.2. Conditions for Funding

Funding for home care services is subject to several conditions. From the beneficiary's side, individuals must have a medical indication and approval from the relevant authority. This applies to all care acts. To determine under which act the care should be provided and funded, the severity of the medical condition and specific care needs are leading (Ministerie van Volksgezondheid, Welzijn en Sport, 2022a, 2024a). If the care is required due to a physical illness or disability, a psychogeriatric disability, an intellectual disability, a sensory impairment, or a mental illness of chronic nature (lasting a lifetime) requiring 24-hour care, the care falls under the Long-term care act, in which case the medical indication is given by the CIZ. When the care falls under this act, the care administration offices are in charge of organising care for the client. If the care needs do not require 24-hour monitoring or when a client is well capable of determining when to call for help, is physically capable of calling for help, and if the risk while waiting for called help is not directly dangerous, the municipality or insurance company can provide support and care. The divide between the WMO and ZVW acts comes down to a difference in requiring domestic assistance or nursing support.
Financial contributions are adjusted based on income, with higher-income individuals required to contribute more towards their care costs (CAK, n.d.). Additional criteria may include residency status and the absence of alternative means to receive the required care.

Tax relief measures allow individuals to deduct eligible healthcare expenses from their taxable income if costs meet a certain threshold (Table 4) (Belastingdienst, 2024). Based on the income category of a person, the threshold of the expenses is between 1–3% of total income, with the lowest income category having no threshold to deduct the expenses. To be eligible for this deduction, the client must have a medical indication, the received care must not be covered by any of the other care acts, and clients must present proof of payment with the date of receiving care, the amount of the costs, and the name and address of the care provider (Belastingdienst, 2023c). This care provider can be anyone (public or private home carers, family members, as long as an agreement is in place and proof of billing is provided. Fees to the insurance or CAK cannot be deducted.

4.3. Determination of Financial Support

The amount of financial support provided for home help is determined based on a detailed medical assessment. This assessment evaluates the intensity and type of care required by the individual. The specific needs are then discussed with municipalities, insurance companies, or care providers to tailor the care package accordingly, ensuring the support meets the individual's needs without imposing unnecessary financial burdens (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). Table 5 shows the total expenditure of financial support provided per institution.

4.4. Choice of Services and Workers

Disabled adults and elderly care recipients have considerable choice in selecting the services and workers financed by policy instruments. If the care is funded by a personal budget (PGB), clients can directly choose their caregivers. For additional care not covered by standard funding, clients can seek tax relief for their expenses, providing them with flexibility in managing their care needs (Ministerie van Algemene Zaken, 2024c).

4.5. Responsible Authorities

The implementation of the various policy instruments for home care and cleaning services involves multiple authorities. Municipalities are responsible for managing social support and domestic help services under the WMO. Insurance companies handle the provision and funding of home medical care under the ZVW. Healthcare providers deliver the actual care services and manage the coordination of care for individuals (Ministerie van Volksgezondheid, Welzijn en Sport, 2022b, 2023a).

4.6. Private Funding

Home care in the Netherlands can also be covered by private insurance, life insurance, or other private schemes. However, private funding options typically require alignment with a medical indication. **If the care needs do not meet the criteria for public funding, the costs must be borne entirely by the clients** . Private insurance plans may offer additional coverage for services not included in public insurance schemes (Ministerie van Volksgezondheid, Welzijn en Sport, 2024e).

5. Regulatory Instruments for Home Care and Cleaning Services

5.1. General Conditions for Authorization

To be authorized to provide home care and cleaning services, providers must meet several general conditions. They must register with the Dutch Chamber of Commerce (KVK), and while cleaners do not require specific licenses, they are recommended to undergo specialized training (Hoekstra, 2024). Home care workers providing medical assistance must have at least an MBO 4 level nursing degree (Ministerie van Volksgezondheid, Welzijn en Sport, 2024d). Both home care workers and cleaners must obtain a Certificate of Conduct (VOG) to ensure they have no criminal record that would disqualify them from working with vulnerable populations (Ministerie van Volksgezondheid, Welzijn en Sport, 2024d).

5.2. Quality Control

The quality of services in the home care sector is controlled by several authorities. The Inspection for Health Care and Youth (IGJ) oversees the quality of healthcare services, including home care. The Dutch Healthcare Authority (NZa) regulates tariffs and ensures compliance with healthcare regulations, while the Authority for Consumers and Markets (ACM) monitors competition and protects consumer interests in the healthcare sector (Ministerie van Algemene Zaken, 2022). For the cleaning sector, no specific organization oversees the quality of services, but providers are expected to adhere to general labor and consumer protection laws (Hoekstra, 2024).

5.3. Price Regulation

Prices for subsidized medical care are regulated by the NZa, which sets maximum tariffs based on the type and conditions of care provided. For non-subsidized care, prices are determined by the providers, generally adhering to minimum wage laws to ensure fair compensation for workers (Nederlandse Zorgautoriteit, n.d.).

5.4. Market Intermediaries and Care Platforms

In the Netherlands, market intermediaries in the home care sector include temporary work agencies and digital platforms. Temporary work agencies operate within the standard regulatory framework, subject to stringent labor laws and operational requirements. Digital platforms, such as Helpling, represent a relatively new and evolving segment. These platforms often function as connectors rather than traditional agencies, which has led to varied regulatory responses.
For example, Helpling, an international domestic help platform, was classified as a temporary work agency due to its contractual setup, where workers had contracts with the platform. This classification required Helpling to adhere to stricter labor regulations, ultimately contributing to its bankruptcy. Other platforms have not yet faced similar regulatory scrutiny, and their legal status remains less defined, with each case being evaluated individually (Facto, 2023).

5.5. Migration Regulations for Home Care Workers

Employers are required to verify the immigration status of their employees. This involves checking residence permits and ensuring that migrant workers have the legal right to work in the Netherlands (Ministerie van Sociale Zaken en Werkgelegenheid, 2022). Employers must comply with these regulations to avoid penalties and ensure fair treatment of migrant workers. The number of migrant workers in the home care sector is relatively low in comparison to the overall economy (9% vs 15%) (Ministerie van Justitie en Veiligheid, 2022). This could be explained due to the majority of care workers requiring medical degrees to Dutch standards, and potential language barriers between workers, companies, and clients.

5.6. Living at Home vs. Institutional Care

Indicators on the percentage of people over 70 living at home versus in institutional care provide insights into the effectiveness of home care services. *Table 6* provides an overview of people over 70 living at home or in institutional care. The Netherlands has a high percentage of elderly individuals living at home. This could imply that the home care sector is successfully enabling independent living for older adults. However, since 2013, due to the policy emphasis on people living at home longer and budgets cuts for the care sector, 800 nursing homes were closed, reducing space for older persons to move into a specialized institution (NOS, 2023). In 2023, 22.218 people were on the waiting list for a nursing home, confirming the lack of space as a partial reason for the high living at home rate.

5.7. Companies in home care sector

The home care sector has over 30000 companies providing care to clients. An overview of the number of companies by the number of working persons within the company can be found in *table 7*. The majority of the companies consists of 1 person working in the company.

Although not specified in this particular data, these workers are most likely independent workers without personnel, a form of entrepreneurship unique to the Netherlands (Ministerie van Sociale Zaken en Werkgelegenheid, 2019). This model of solo entrepreneurship in the home care sector is likely popular for several reasons (Tabak, 2023). Firstly, it offers flexibility and autonomy to workers, allowing them to set their schedules and choose their clients. Additionally, it enables personalized care delivery, with clients forming direct relationships with their caregivers. Moreover, for those with specialized skills or niche services, such as language-specific care or cultural competence, operating independently allows them to cater directly to their target demographic. Regarding the cleaning sector, currently no companies are known to cater to in-home cleaning, instead focusing on business-to-business cleaning.

Home care companies within the public sector are often considered public benefit organisations (ANBI). This status is associated with a specific type of non-profit organization catering almost all of it's work to the benefit of the public. To qualify as an ANBI-organisation, an institution in the home care sector must meet several criteria (Belastingdienst, 2023b). Firstly, it must be entirely focused on serving the general interest, as evidenced by its statutory objectives and planned activities. The institution must primarily serve the public interest in nearly all of its activities, meeting the 90% requirement. It must operate without a profit motive in its activities aimed at serving the public interest. Both the institution and those directly involved must meet integrity requirements, ensuring that no individual or entity treats the institution's assets as their own. Governance should not be dominated by any individual or group, ensuring the institution's assets are used solely for its mission. The institution's assets should be limited to what is reasonably necessary for its work, keeping its own funds minimal. Compensation for decision-makers is limited to expense reimbursement or minimal fees. The institution must have a current policy plan and maintain a reasonable ratio between administrative costs and expenditures. Any remaining funds after dissolution must be allocated to another ANBI or a foreign institution primarily serving the public interest. Additionally, the institution must meet administrative obligations and publish specific data on its website. Noteworthy, this also allows companies within the private sector to qualify for the ANBI-registration.

Table 1: People with a CIZ indication by form of care (absolute numbers and % of total population)

	2017	2018	2019	2020	2021	2022
Total forms of care	294235 (1,71)	299000 (1,73)	309280 (1,78)	314400 (1,80)	342095 (1,95)	358490 (2,01)
Care in kind with stay	201450 (1,17)	203610 (1,18)	205265 (1,18)	202630 (1,16)	215895 (1,23)	219465 (1,23)
Care in kind at home full	10490 (0,06)	12060 (0,07)	13215 (0,08)	14405 (0,08)	17945 (0,10)	21850 (0,12)
Care in kind at home modules	30545 (0,18)	35590 (0,21)	41380 (0,24)	45060 (0,26)	52035 (0,30)	59035 (0,33)
Care in kind form unknown	540 (0,00)	330 (0,00)	305 (0,00)	135 (0,00)	120 (0,00)	65 (0,00)
Exclusively care in kind	233840 (1,36)	241380 (1,40)	248100 (1,43)	249625 (1,43)	270580 (1,54)	282330 (1,59)
Exclusively PGB	30860 (0,18)	32000 (0,19)	33400 (0,19)	36295 (0,21)	40150 (0,23)	41940 (0,24)
Combination care in kind/PGB	8935 (0,05)	10005 (0,06)	11765 (0,07)	12440 (0,07)	15185 (0,09)	17825 (0,10)
Not receiving care	20600 (0,12)	15610 (0,09)	16010 (0,09)	16035 (0,09)	16180 (0,09)	16390 (0,09)

Source: https://mlzopendata.cbs.nl/#/MLZ/nl/dataset/40077NED/table?dl=61D89

Table 2: People using care under WMO-act by type of care (absolute numbers)

	2019	2020	2021	2022	2023*
Total	1134155	1188130	1208900	1215640	1223105
Non-medical support at home	254950	262650	257240	254165	250955

Domestic help	439060	496575	509425	527395	536015
Home adjustments & other services	757850	771075	774135	773500	776150

Source: https://mlzopendata.cbs.nl/#/MLZ/nl/dataset/40085NED/table?dl=67EDA

Table 3: People using care under ZVW-act by form of care (absolute numbers)

	2017	2018	2019	2020	2021	2022
Total form of care	227040	222435	214855	225175	219650	209035
Personal budget (pgb)	15055	15725	15800	15060	13580	12505
Total care in kind	212810	207700	200100	211385	207205	197575

Source: https://mlzopendata.cbs.nl/#/MLZ/nl/dataset/40052NED/table?dl=1F1F1

Table 4: Threshold per income for tax relief eligibility (euro)

Percentage of income	2017	2018	2019	2020	2021	2022	2023	2024
No threshold	0–31.118	0–31.367	0–31.744	0–32.252	0–32.769	0–33.195	0–35.287	0–38.638
1%	31.118–46.676	31.367–47.050	31.744–47.615	32.252–48.377	32.769–49.152	33.196–49.791	35.288–52.928	38.638–57.954
2%	46.676–62.228	47.050–62.726	47.615–63.479	48.377–64.495	49.152–65.527	49.792–66.379	52.929–70.561	57.954–77.261

3%	62.228+	62.726+	63.479+	64.495+	65.527+	66.379+	70.561+	77.261+

Table 5: Total spendage of financing forms of home care policy institutions (in millions)

	Total all financing forms	Governmental payments*	Longterm care act	Basic insurance	Additional insurance	Private payments	Other financing forms
2017	17933	1826	9873	4876	0	1348	11
2018	18989	2109	10463	5125	0	1283	10
2019	20583	2247	11887	5133	0	1306	11
2020	23289	3533	13300	5090	0	1355	11
2021	23693	2821	14229	5207	0	1426	11
2022	23845	2406	15028	4887	0	1514	11

* Funding by national government, provinces and municipalities

Source: https://opendata.cbs.nl/#/CBS/nl/dataset/84053NED/table?ts=1717503579804

Table 6: People over 70 living at home or in institutional care (absolute numbers)

Year	Total	At home	In institutional care
2017	2,144,019	2,031,028	112,991
2018	2,239,579	2,122,838	116,741
2019	2,320,930	2,203,249	117,681
2020	2,396,507	2,274,319	122,188
2021	2,453,757	2,333,721	120,036
2022	2,508,137	2,386,270	121,867
2023	2,570,546	2,443,381	127,165
2024	2,629,626	2,497,781	131,845

Source: https://opendata.cbs.nl/#/CBS/nl/dataset/37620/table?dl=3EC40

Table 7: Companies in home care sector by number of working persons (absolute numbers and % of total home care companies)

	2017	2018	2019	2020	2021	2022	2023	2024
Total companies	14560	16805	19430	21470	23725	27150	31530	32605
1 working person	13515 (92,82)	15630 (93,01)	18115 (93,23)	20070 (93,48)	22180 (93,49)	25610 (94,33)	30030 (95,24)	31095 (95,37)
2 working persons	335 (2,30)	390 (2,32)	450 (2,32)	485 (2,26)	545 (2,30)	545 (2,01)	555 (1,76)	550 (1,69)
3 – 5 working persons	155 (1,06)	170 (1,01)	210 (1,08)	235 (1,09)	250 (1,05)	245 (0,90)	235 (0,75)	240 (0,74)
5 – 10 working persons	170 (1,17)	200 (1,19)	235 (1,21)	255 (1,19)	295 (1,24)	295 (1,09)	270 (0,86)	270 (0,83)
10 – 20 working persons	155 (1,06)	155 (0,92)	170 (0,87)	190 (0,88)	180 (0,76)	185 (0,68)	175 (0,56)	175 (0,54)
20 – 50 working persons	100 (0,69)	135 (0,80)	120 (0,62)	105 (0,49)	135 (0,57)	135 (0,50)	125 (0,40)	130 (0,40)
50 – 100 working persons	45 (0,31)	40 (0,24)	45 (0,23)	45 (0,21)	45 (0,19)	45 (0,17)	55 (0,17)	55 (0,17)

Source: https://opendata.cbs.nl/#/CBS/nl/dataset/81589NED/table?ts=1717505383105

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