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COMPARATIVE ANALYSIS OF NATIONAL REPORTS ON HOME CARE POLICIES

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The diversity of European home care and household services markets

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1. Introduction

In the last 20 years, many European countries have changed the rules under which elderly care is publicly financed and regulated. They have supported the development of cash for care (like in Austria, Germany, Italy, the Netherlands, Spain, Ireland), investment subsidies, vouchers systems (like in France and in some territories in Italy), tax breaks for care (like in Denmark, the Netherlands, Ireland, France), public procurements rules (Mercille, 2024; European Commission, 2022; Zechner *et al*, 2022; Ledoux, Shire and van Hooren, 2021; Le Bihan, Da Roit and Sopadzhyan, 2019; Carbonnier and Morel, 2015; Brennan *et al*, 2012; Ungerson and Yeandle, 2007). Purchasers and providers have been split, meaning that “provider units” providing institutional and home care have been separated from “public units” involved in funding, planning, and purchasing services (European Commission 2022: 33).

These policy changes have supported the transfer of public funds to private care providers and workers, which led care being increasingly distributed through the market (marketisation of care). They have also brought states to provide less themselves but instead stimulate and support the development of a care supply provided by private actors active in care markets more or less organised by states and, indirectly, the European Union¹.

These changes have been motivated by several arguments. 1) The idea that market options could support cost containment. This argument has been accompanied by the belief that the market can provide cheaper solutions and would be more efficient. 2) The idea that marketisation could also provide private investments in care. 3) The emphasis on the agency of individuals and their ability to exercise their free choice within the market (European Commission, 2022; Stolt, Blomqvist and Winblad, 2011). Consequently, families and care recipients have increasingly be seen as consumers who must make decisions about the supports and services they purchase (Farris and Marchetti, 2017). These changes concerning the financing, organisation and provision of care services have profoundly altered the conditions under which care is provided in Europe. They have also fostered the development of new actors on home care / household services for disabled and elderly people and determine the shape of them.

To varying degrees according to the country, private providers and the share of private actors in the provision of care have grown (Mercille, 2024; European Commission, 2022). Processes of privatization have also been observed, implying a shift in the ownership structure from public to private. For profit companies of different sizes have also emerged and grown in many of the member states in the care sectors. In the domiciliary sector, while there was no profit-providers in many countries in the 1980s like Germany, Finland, and France, in 2019, according to the Federal Statistical Office (Destatis 2020), 66.5% of

¹ The providers mandated by public authorities are excluded from the 2006/123/CE service Directive contrarily to those that are not mandated, meaning that authorisation procedures applying to them should apply a non-discriminatory principle between the providers, in order to enhance competition.

German home help and care services were commercial services against 2.7% public providers and 30.8% not-for-profit services. In Finland, while for-profit providers were absent from the home services care market in the 1980's, they represented 20% of all services in 2018 (Zechner *et al.*, 2022, p.56). In France, the number of hours provided by for-profit firms providing household services including care have had a growth of 6.02% between 2019 and 2021, while it was diminishing in the public and non-profit sector (Beltzung and Cadillac, 2024). Profit-providers sometime have also supported a logic of corporatisation in the provision of care, meaning that business logics are applied to care and that additional costs related to marketing, finance counselling have begun to appear or increase (Hoppania *et al.*, 2021; Farris and Marchetti, 2017).

The actors and activities developed have been different according to the countries. In some countries, like the Netherlands, Italy and Germany, the home care marketisation has led to the development of small companies, mostly non-profit in Italy and the Netherlands (Hesselink and Been, 2024), while in other countries like France and Ireland, franchised and/or multinational providers have also emerged (Mercille and O'Neill, 2022; Ledoux, de Muñagorri and Guiraudon, 2021; Ågotnes, Jacobsen and Szebehely, 2019).

Public and non-profit providers have been affected by these trends, especially when they are competing with for-profit private providers. The consequences of these trends depend on whether the competition develop over price or quality (European Commission, 2022). Even if multilevel quality dimensions have been developed and distinguished², service quality is difficult to operationalise in the care sectors, because of the intersubjective dimension of care. In many countries, market competition in social services has led to competition on price rather than quality and have put pressure also on public and non-profit providers to also adapt (Meagher and Szebehely, 2013). Price competition leads to a reduction in the wages and quality of long-term care services, as providers seek to compensate for lower prices by compromising the quality of services and employment (European Commission, 2022, p.34). Scandals in the residential care sector and the labour shortages have nevertheless led some member states to try to better regulate the quality of the services (like in Ireland, see Murphy, 2024) and of the employment situation (see report 2.2 of the ORIGAMI project). In some cases, the welfare policies have supported the development of informal markets of care and / or household services, like in Italy, Spain and at some point, in the Netherlands and Ireland. Welfare state policies' transformations therefore lead to the development of different types of architectures of markets.

These policies are central in the organisation of home care and household services markets. Therefore, they can determine the place and shape of care / household services platforms. They provide 1) financial and 2) regulatory instruments (Ledoux, Shire and van Hooren, 2021). 1) Financial instruments stimulate the development of home care and household services. They can support either demand or supply. They can also direct them to different segments of the market (institutional home care, in-kind home care or household services

² implying *structural quality* (number of workers per beneficiary, educational level of the workers), *process indicators* and *outcomes* (mortality, satisfaction levels...)(Stolt, Blomqvist and Winblad, 2011, p.562)

having (or not) to respect certain conditions, care assistants employed by households...). 2) Regulatory instruments can participate in the definition of what home care and household services are, what can be bought under which conditions, what kind of boundaries exist between the different segments of the markets. They can support trust in the market, but they can also create barriers to entry for certain actors or shape the benefits they can create. Again, the regulatory tools do not apply to all types of actors and exchanges in home care markets. While comparative research has mostly considered home care and households services policies in their relation towards “the” market (Le Bihan, Da Roit and Sopadzhiyan, 2019), it is central to understand how welfare state organise the architecture of home care and households services markets, the weight and the shape of their different segments, in order to later be able to explain the place and the shape of household services and home care platforms.

This report concentrates on home care and household services accessible to a specific population: older and disabled people. The different countries selected in the ORIGAMI project give an overview of contexts having a different demand and organisation of home care and household services for older people and disabled. The demographics of these countries differ and they are known for having developed different types of care policies for disabled and older people.

Demographically (see table 1): Italy, Spain and France have the highest share of population aged 65 years and of 80 years and more, while Ireland has the lowest (respectively 15,1% and 3.6%) And France and Italy have also the highest share of population considerate as dependant, meaning that these countries face a higher demand for care.

Table 1: Composition of the elderly population

	Share of 65 years or more as % population in 2022	Share of 80 years or more as % population in 2022	Number of people considered as dependant (in thousands) aged 65 or more in 2022	Share of people aged 65 or more considered as dependent in 2022
Ireland	15.1	3.6	110	14.1
Netherlands	20.1	4.9	501	14.1
Denmark	20.4	5.1	140	11.6
Spain	20.2	6.1	1,316	13.6
France	21.1	6	3,425	23.8
Italy	23.9	7.6	2,292	16.3

Source: Ageing Report, European Commission, 2024 and own calculation

While the welfare state literature has been heavily discussing the notion of “care regimes” (Daly, 2021; Daly and Rake, 2003; Leitner, 2003; Knijn and Kremer, 1997; Orloff, 1993; Lewis, 1992), the more recent literature has tried to capture the marketisation of care regimes in its relation to informal care, from the perspective of the family members and renewed the debate over familialization versus defamilialization (Le Bihan, Da Roit and Sopadzhiyan, 2019). Policies supporting the family’s caring function are here considerate as an indicator

of familism. Leitner proposes to distinguish four types of care policies: implicit familism, explicit familism, optional familism and defamilism (Leitner, 2003). In *implicit familism*, both defamilizing and familizing policies are weak, “informal care is not supported and there is no alternative to it”(Leitner, 2003). *Explicit familism* corresponds to a type in which policies support the caring family and there are no alternatives to it. In *optional familism*, familizing and defamilizing options are present. In *defamilization*, there are extensive care services and no familizing policies. Saraceno, Le Bihan, da Roit and Sopadzhian have added the market dimension to this typology (Le Bihan, Da Roit and Sopadzhian, 2019; Saraceno, 2010). Le Bihan, da Roit and Sopadzhian distinguish between defamilism, defamilism through the market, unsupported familism, supported familism, optional familism through the market, optional familism (ibid.). They describe a trend in many countries towards *optional familism through the market*, especially in Italy, Spain, France while the Netherlands would have moved to *optional familism* (Le Bihan, Da Roit and Sopadzhian, 2019, p.589). Ireland and Denmark, not considered in Le Bihan et al.’s study could correspond to *optional familism* through the market.

At the beginning of the 1990’s, the southern countries (Spain and Italy) were considered as countries that had an unsupported familism in Le Bihan et alii’s classification, since they neither offered defamilization nor actively supported the caring function of the family. Families were the primary care provider, since state subsidised support was limited (Leitner, 2003). Italy and Spain (and also France) had (and still have) a legal obligation to provide relatives with support (Le Bihan, Da Roit and Sopadzhian, 2019). Later, with the increased participation of women in the labour market and the disappearance of extended families, these countries increasingly relied on informal care and were supported to do so. This led families to rely on migrant workers to care for their oldest members, while in-kind services remained scarce. Therefore, Spain and Italy have been considered as countries turning to optional familism through the market during the second decade of the XXI century (Le Bihan, Da Roit and Sopadzhian, 2019) developing a “migrant in the family model”, where migrant workers were filling the care deficits (Van Hooren, Apitzsch and Ledoux, 2019; Van Hooren, 2012).

In France and Ireland, the family is also strengthened in caring for older people through familistic policies and at the same time, policies offer them market alternative. They can therefore also be considered as corresponding to the “optional familism through the market” type. In France, while children can still be asked to pay for their parents nursing home, the introduction of the long-term care allowance APA (*Allocation d’aide à l’Autonomie*, APA) has introduced a new market for home care services. Ireland can be considered as corresponding also to this category, since family obligations are also still pregnant, through generous family carers benefits, but different types of markets have developed around elderly care. The home care system is characterised by modest benefits, and the enforcement of strict eligibility criteria, but the state has developed a substantial public supply of long-term care (in-kind home care services and institutional care) in the recent decade (Mercille and Lolich, 2024; Murphy, 2024).

Netherlands on its side moved from defamilialism to optional familialism (Le Bihan, Da Roit and Sopadzhiyan, 2019). While the country used to have an encompassing long term care system, the introduction of the Social Support Act (WMO) in 2007 changed it. It indeed decentralizes the responsibility for home care and social support services to municipalities, which have aimed to support informal caregiving (Le Bihan, Da Roit and Sopadzhiyan, 2019, p.590).

Denmark could be considered as belonging to optional familialism through the market, since it still has one of the most comprehensive long-term care system. Care services are heavily subsidized by the state, but are increasingly provided by a mix of public and private care and cleaning providers. The family has also gained a more prominent role in caring for older people. In particular, older people living with a partner often receive lower levels of care and the proportion of informal carers has increased over the last decade (Larsen and Ilsoe, 2024).

Table 2: Types of care policies according to the Le Bihan et alii. Existing typology (Le Bihan, Da Roit and Sopadzhiyan, 2019)

	Type of familialism
Ireland	optional familialism through the market
The Netherlands	optional familialism
Denmark	optional familialism through the market
Spain	optional familialism through the market
France	optional familialism through the market
Italy	optional familialism through the market

These typologies show a convergence movement towards optional familialism through the market, in relation with governments prioritizing free market ideologies and privatisation (Lightman, 2024; Giordano, 2022). They are more developed from the point of view of the family members, without considering the diverse statuses of the extra-familial care workers providing help. Is it the same to be helped by an undeclared private household assistant in Italy, supported by the Italian cash for care scheme and to choose a care provider financed by the APA scheme in France? Are the regulatory schemes really comparable? Aren't there any differences in the architectures of home care and household services markets in Spain, Italy, France, Ireland, Denmark, which could also bring to disentangle the category "optional familialism through the market"? While alternative typologies have insisted on the

composition of (Lightman, 2024; Giordano, 2022) the workforce, the objective of this report is to look at how welfare state policies contribute to organise and shape the architectures of home care and household services markets for older and disabled people in Ireland, the Netherlands, Denmark, Spain, France, Italy. Part of the ORIGAMI project, it can help to better understand how the different market structures, organised by welfare states and pre-existing the emergence of home care and household services platforms can create resources and constraints to which platforms have to adapt to. The report takes seriously the idea that these market structures are composed of different segments, constituted of services or work which, in certain cases can be considered as “different” (a private household assistant in Italy could be considered as producing something different to an in-kind service proposed by the municipality) and between which citizens cannot always easily navigate (Apitzsch and Shire, 2021; Hooren, 2021). The following parts look more into details of the different policy instruments used in the segments of the home care and household services markets and how they shape the architectures of the markets. We begin with the financing instruments (1) before continuing with the regulatory instruments (2).

2. Funding

In all the different countries selected in the ORIGAMI project, private insurances, life insurance or other private schemes covering long term care do exist but are still quite marginal in comparison to public spending. The different countries nevertheless do not dedicate the same percentage of GDP to public expenses for care. While the Netherlands and Denmark dedicate more than 3% of their GDP on long term care, France, Italy Ireland and Spain spend less than 2% (see Table 3).

Nevertheless, since the percentage of the population aged 65 and more is not the same, these public expenses dedicated to long term care expressed as percentage of GDP could have a different meaning. For example, while Ireland ranks lowest in the EU 27 as a percentage of GDP, based on 2020 figures, Ireland ranks above the EU average on per capita spent (Murphy, 2024). Nevertheless, Spain and Italy range in the second half of the countries under study in terms of public spending for care while they are also in the group of countries having the oldest population. This means that their public resources dedicated for long term care in general are limited or scarce and will meet with difficulties old people's needs.

Table 3: Public long term care spending as % of GDP and % of older people aged 65 years and more receiving different forms of services and benefits in 2022

	Long term care spending on institutional care as % of GDP	% of older people aged 65 years and more receiving institutional care (in thousands)	Long term care spending on home care as % of GDP	% of older people aged 65 years and more receiving home care (in thousands)	Long term care spending on cash benefits as % of GDP	% of older people aged 65 years and more receiving cash benefits (in thousands)	Long term care spending on care as % of GDP
Netherlands	2	1.0	0.6	3.6	1.2	0.2	3.8
Denmark	1	0.8	2	2.8	0	0	3
France	1.1	0.9	0.7	1.2	0.1	0	1.9
Italy	0.4	0.6	0.3	1.3	0.9	2.4	1.6
Ireland	0.5	0.5	0.4	1.2	0.3	1.1	1.2
Spain	0.5	0.6	0.2	0.8	0.1	0.5	0.8

Source: Ageing Report, European Commission, 2024 and own calculations

Beyond the general level of public spending for long term care, the types of care supported by the different countries is different, this having also consequences for on home care and household platforms. Public spending for institutional care cannot be used for platforms dedicated to home services but important spending on institutional care can diminish the pressure on home care and household services and their platforms. On the contrary, important resources dedicated to home care services/benefits for dependent persons might flow into care and household services platforms. Cash benefits are sometimes associated with family members leaves and might not always be able to be used to buy extrafamilial work. But in some cases, cash benefits can also be used to pay care work provided by extra family members. If home care is organised as a “service”, specific regulatory instruments might also be attached to it.

2.1. Distribution of long-term care public spending in the different countries.

In all countries, a trend of deinstitutionalisation is observed but the structures of long-term care expenses are different. We first look at expenses for institutional care, before moving to expenses for home care services and benefits. According to the EU Commission terminology:

- home care refers to long-term care in-kind benefits delivered in the private home of the care recipient.
- institutional care refers to in-kind benefits delivered in a specialised institution in which the care recipient lives.

- cash benefits are payments given to care recipients or their families so that they can purchase care directly themselves (European Commission, 2024).³

In all countries under study, a trend of deinstitutionalisation can be observed. For example, since 2013, due to the policy emphasis on people living at home longer and budgets cuts for the care sector, in the Netherlands, 800 nursing homes were closed, and in 2023, 22,218 people were on the waiting list for a nursing home (Hesselink and Been, 2024). Nevertheless, the support of institutional care in comparison to home care and cash benefits is still not the same in the different countries. While the Netherlands, Denmark and France still spend more than 1% of their GDP on institutional care, Italy, Ireland and Spain spend 0.5% only or less. Considering the important care demand in Italy, this country has the lowest number of beds in long-term care facilities in Europe (Diodati, 2022). Spain spends only 0.5% of its GDP on institutional care, but nevertheless 62% of its long-term care expenditure are targeted to institutional care, meaning that this subsector is still the one where resources are concentrated (table 4). This Spanish landscape of long-term care has been heavily transformed by the consequences of the 2008 crisis. The number of people generally entitled to LTC services has decreased since the 2008 crisis and waiting lists have increased (Godino and Molina, 2024). In fact, the National Reform Program of 2012, imposed to adapt the long-term care policies implementation to the available funding, increased the co-payments, and fostered the expansion of the private sector (ibid.).

Table 4: % of total national public LTC spending in institutional, home care or cash benefit options in 2022

	% of long-term spending dedicated to institutional care	% of long-term spending dedicated to home care	% of long-term spending dedicated to cash benefits	Total
Netherlands	52.6	15.8	31,6	100
Denmark	33.3	66.7	0	100
France	57.9	36.8	5,3	100
Italy	25	18.8	56,3	100
Ireland	41.7	33.3	25	100
Spain	62.5	25	12,5	100

Source: Ageing Report, European Commission, 2024, own calculations

If we turn to **home care services**, high public investments characterize Denmark in this sub-sector, with 66% of the total long-term care expenditures dedicated to it, corresponding to 2 percent of GDP of the budget expenditure in 2022, which is the highest (Tables 3 and 4). Denmark is the country which invests more of its public expenses in home care services. The Netherlands and France public expenses on home care services also represent more than 0.5% of their GDP, but considering the high level of long-term care

³ Data on overall long-term care expenditures and its breakdown by care setting is not available from a single source for every EU Member States and has been collected in the Ageing Report by the Member states. There is no overlap between institutional and home care services but an overlap could exist between home services and cash benefits (with families using the cash benefits with which they could provide the co-payment of their home care)(European Commission, 2024, p.104).

expenses in the Netherlands, the country spends only 15.8% of its long-term care expenditures on home care services. In the Netherlands, the responsibilities for the different care sub-sectors (home care and institutional care) are well delineated and people do not have the choice between them. Institutional care is reserved for the most severe cases and a medical assessment determines the severity of the dependency and whether it is strong enough for going in a care home. If the dependent people need 24-hour care, they fall under the Long-term care act: the care administration offices are then in charge of organising care for the client, in a care home. If the care needs do not require 24-hour monitoring or when a client is capable of determining when to call for help and of calling for help, and if the risk while waiting for called help is not directly dangerous, municipalities or insurance companies are responsible for delivering care (Hesselink and Been, 2024). The divide between the municipalities (under the Social Support Act, WMO) and the health insurances (under the Health Insurance Act, ZVW) comes down to a difference in requiring domestic assistance or nursing support. This means that in the Netherlands, the welfare state participates to construct institutional boundaries between institutional care, home care and household services and still concentrates its efforts on institutional care. In other countries, like France, citizens having the same level of autonomy loss (levels 4,3,2,1 of the national grid in France) might stay either in their own home or in a nursing home. Finally, Ireland, Italy and Spain spend less than 0.4% of their GDP on home care services, with Italy and Spain concentrating less than one third of their expenses on these services.

The amount dedicated on cash benefits is also different. The European Commission does not consider (all) the cash-for care allowances from Denmark and France as cash benefits, because they are conditioned to the delivery of a service closely traced, like through a voucher. On the contrary, Italy is one of the few EU countries to invest more than half of its total national LTC spending in a cash benefit (*Indennità di accompagnamento*, IDA) dedicated to dependant persons (see table 4; Pais and Bonifacio, 2024; Pavolini and Ranci, 2008). After Italy, the Netherlands and Ireland have also generous cash benefits dedicated to dependent people.

The percentages of long-term care expenditure devoted to institutional care, home care and cash benefits also give an idea of the preferences that governments and citizens have for the various possible care policy options and the corresponding care segments. While Denmark and the Netherlands can be considered as the countries spending the most on home care services and cash benefits, they also spend important resources on institutional care, but with a tendency to decrease the efforts on this sub-sector. In France and Ireland, the resources dedicated to home care and cash benefits are limited (less than 1% of the GDP). In Spain, home care and cash benefits are less prioritised than institutional care and the public resources dedicated to home care are limited (0.3% of GDP or less). Finally, in Italy, the welfare system is financially imbalanced in favour of cash benefits, with limited investment in institutional care. When limited institutional options exist, this leads to comparatively increase the demand for home care and household services. Table 5 resumes this result.

Table 5: Percentage of Public long-term care spending on home care and cash benefits as percentage of GDP

	Long term care spending on home care services and cash benefits as % of GDP	Resources dedicated to home care for dependent people
Denmark	2	IMPORTANT with also important resources dedicated to institutional care
The Netherlands	1.8	
Italy	1.2	IMPORTANT without important resources put on institutional care
France	0.8	LIMITED with also important resources dedicated to institutional care
Ireland	0.7	LIMITED without important resources put on institutional care
Spain	0.3	SCARCE without important resources put on institutional care

Beyond the amount of the spending, the policy instruments distributing them are associated with different conditions, which contribute to shape the architecture of the welfare markets for older and disabled people in the home care and domestic work sub sectors. All the countries at stake organise in-kind services at home and all have some cash for care, differently organised.

2.2. In-kind home services supported and directly organised by public authorities or health insurances

In all countries studied, there exist universal in-kind home care services. Sometimes, household services are also proposed. Their content and availability differ (table 6). Denmark and Ireland are the only countries in this study where the public authorities responsible for home care and household services do not charge the care recipients: it is only for meal on wheels that co-payment is required (Larsen and Ilsoe, 2024). In France, the Netherlands and Italy, this co-payment is also income modulated. In some of the countries, means tested schemes also exist (like the WMO in the Netherlands), and sometimes layer on other schemes (like the social assistance scheme in France, not represented on table 6). While the same policies concern both older and disabled people (in the Netherlands, Italy and Denmark), it is not the case everywhere, especially not in France and in Ireland. In Ireland, there is no automatic right to home care for older persons.

Table 6: Conditions and levels of long-term care in-kind benefits directly supported and organised by public authorities or insurances

	Authorities in charge	Conditions	Amount and shape on the service
The Netherlands	Health insurances and	– Medical needs (under ZWZ): Theoretically all	– Medical needs: different levels, co-payment – Non-medical needs: means tested, depending on the municipalities

(ZWZ and WMO)	local governments	citizens covered by the health insurance–depending on needs – Non-medical needs: means tested (under WMO)	
Denmark	Local authorities	Universal – depending on needs	Free for those deemed to need it. Different levels. Local authorities decided the level of home help and practical services. Copayment limited to meals on wheels.
France (APA and PCH)	Subnational authorities (<i>Départements</i>)	Universal – depending on needs	Co-payment income-modulated. Different levels. National rules implemented by the départements.
Ireland (Home Support Service)	Health Service Executive	Universal – depending on needs	Free for those deemed to need it. Different levels. National rules implemented by the HSE. However additional supports, over and above the level funded by the HSE must be paid for the by individual.
Spain	Regional governments	Universal – depending on needs	Co-payment Different levels. Limited availability
Italy (ADI and SAD)	Municipalities	Universal – depending on needs	Co-payment of SAD, income modulated and depending on local authorities' policies but limited availability

In Denmark, in kind services are either public or private, they are governed by local authorities which condition the distribution of public money to strong conditions. Local authorities must approve all public and publicly subsidized private care providers, as well as home care workers and cleaners providing services to older or disabled adults (Larsen and Ilsoe, 2024). Access to home help and practical care services, including the level of care, is subject to a needs assessment. Every individual has the right to a care needs assessment, a rehabilitation assessment and a final decision. It is the individual local authority that makes the assessment, sets the eligibility criteria, which must be publicly available, and decides on the level of home help and practical services. Local authorities manage the delivery of home help and cleaning services, which are generally publicly funded, though some elements, like meals on wheels, may require self-financing (ibid.). When municipalities contract care services to private providers, these providers must adhere to local quality standards developed by the authorities, including requirements for skilled care workers, relevant experience, and compliance with social and labour clauses in public tenders. Labour clauses often mandate adherence to sector-specific collective agreements to avoid social dumping, while social clauses may include targets for training, apprenticeships, and employing vulnerable groups under specific conditions (ibid.).

In France, in-kind services are governed by subnational authorities, tied by national regulations. Beneficiaries of the Personal Autonomy Allowance (*Allocation Personnalisée d'Autonomie*, APA), the Disability Compensation Benefit (*Prestation de Compensation du Handicap*, PCH) and the social assistance scheme can receive in-kind services provided by either public, private not profit or private for-profit organisations. The APA and PCH are need-based universal allowances financing an “help plan” (APA) or a compensation plan (PCH) which might be co-paid by the beneficiary. The amount of the co-payment is adjusted based on the applicant's financial means. The APA is eligible only for people aged 60 years or more while the PCH has no age limit but should be asked before 60 years. Both schemes are regulated by national laws and decrees but implemented at subnational level (*départements*), where medico-social staff evaluate the needs according to national grids. The *départements* can finance the plan through a i) prefinanced voucher (the *Chèque Emploi Service Universel*, CESU) ii) subsidizing older people and their families or iii) the *département* can also directly pay the providers. The help plan is individual: it is dedicated to helping only one person in the household and if two individuals are dependent in the same household, then, two plans are required. The PCH is an allowance aimed at compensating the situation of disability. The social assistance scheme (the “*aide financière pour rémunérer une aide à domicile*”) is means tested and can be recoverable from the estates of deceased beneficiaries. Like the APA, this benefit is either directly paid to the provider organisation, or to the beneficiary when they decide to employ directly a worker. As in Denmark, the same authorities (the *départements*) are in charge of financing and authorizing the private care service providers (Ledoux *et al.*, 2024). But contrary to Denmark, they do not control the workers employed by families. Since 2015, organisations providing services to disabled and older people at home have to have an authorization delivered by the *départements*. If a proxy organisation (*mandataire*) helps people to employ a worker and manage the employment relation, these organisations only have to detain an *agrément*, delivered by the deconcentrated central state (and not the *départements*). Organisations providing social assistance have to be *habilitées*, which means that they have to be approved by the *départements*, to apply the tariffs defined by them and to agree to return any profits made to the local authorities (Ledoux *et al.*, 2024).

In the Netherlands, as of 2015, home care services which were previously covered by long-term care insurance have been decentralized either to local governments (in the Social Support Act, WMO) or to health insurance companies under the ZVW (*Zorgverzekeringswet or Health Insurance Act*). This reform involved substantial budget cuts (Hooren, 2021). The ZVW covers basic health insurance, including home medical care, and is mandatory for all residents and is financed through premiums and income-related contributions (Hesselink and Been, 2024). Insurance companies are responsible for arranging care and related tasks (ibid.). Since 2007, the WMO has given municipalities the responsibility for non-medical social support for people in need of long-term care. Municipalities are tasked with assessing individual needs, providing tailored support services, and ensuring residents have access to necessary resources and facilities. Non-medical assistance, such as household cleaning and

maintenance, is provided to those who have a medical need for such services. No assistance is provided to those who do not need these services for medical reasons (Hesselink and Been, 2024; Kelders and De Vaan, 2018). Under the WMO scheme, clients pay an income-based contribution for the services they receive, so that home care services are more often used by people with lower incomes (Hooren, 2021). According to European competition law, local governments under the WMO, have to use recurring tenders to purchase the needs in their jurisdiction (Hooren, 2021). This process has led to fierce competition between existing (non-profit) home care providers and new (for-profit) providers. In the competitive bidding process, home care providers, fearful of losing their market share, began offering services below their actual costs. As a direct result, many providers experienced financial difficulties (ibid.).

In Ireland, the main scheme dedicated to older people is the Home Support Service scheme, managed by the Health Service Executive (HSE), the primary provider of public health and social care services. The scheme primarily targets those over 65 who need support to remain at home or return home after hospitalization, though exceptions are made for younger people with disabilities. For individuals with disabilities, support is provided through the HSE Social Care Division's Disabilities programme, focusing on those with lifelong disabilities that began before age 65 (Murphy, 2024). The Home Support Service includes personal care and essential household tasks, such as assistance with daily activities like getting in and out of bed, dressing, and showering. The level of support varies based on individual needs. These services are either provided by HSE staff or by approved external providers, which can be chosen from a list of approved private or non-profit/voluntary sector organizations. A stipulation explains that workers must not be assigned to provide paid care to a member of their immediate family. The service is free for those who qualify, with no means testing. However additional supports, over and above the level funded by the HSE, must be paid for by the individual (ibid.). Access to the scheme is managed locally through home support offices, and applications are typically completed by the individual needing care. The level of care is determined by a care needs assessment conducted by a health professional, taking into account existing family, social, and community supports. The HSE policy emphasizes that the service is not meant to replace informal care (ibid.). The HSE assesses clients' needs and allocates them to itself (public provision) or to private or non-profit organisations on the tender. When care is outsourced in this way, the HSE pays providers directly for a set number of hours of care (Mercille and Lolich, 2024). When an individual is approved for the Home Support Service but the HSE does not have resources available to deliver the service, the Consumer Directed Home Support Scheme (CDHS) can be used (Murphy, 2024). In that case, an external provider, approved by the HSE, can be appointed to deliver home care arranged by the HSE for the care recipient (ibid.). Alternatively, under this approach an individual can deal directly with an approved provider of their choice to arrange days and times of service delivery. The number of hours that a person can avail of through that chosen provider then depends on the rates charged by that

provider for the days and times that care is required. Payments will not be made to providers who are not formally HSE approved (ibid.).

In Spain, the 2006 Law for the Promotion of Personal Autonomy and the Care of Dependent Persons (LAPAD) transformed a system of residual assistance and social security into one with a universal approach with a subjective right (Cabrero and Gallego, 2012). It guarantees access to various long-term care services, including home help, teleassistance, and residential care, under the System of Autonomy and Care for Dependency (SAAD) (Godino and Molina, 2024). The LAPAD stipulates that in-kind services and care benefits must be integrated into the social services network of the respective regional governments. It also prioritizes services over cash benefits by stipulating that : “if services are not feasible, then an economic benefit linked to the provision of services is assigned” (Cabrero and Gallego, 2012, p.209). Home care services can be provided by public entities or private companies accredited by the regional governments (ibid.). Eligibility is determined through an assessment of dependency, determined according to the frequency and intensity of assistance required. While other countries define the needs according to the capacities of dependent people like in France, in Spain, they are defined with the services in mind. It leads to a personalized care plan including a list of appropriate services or cash benefits according to the level of dependency. The obtention of this financing is tied with conditions. Private companies offering home help must meet specific requirements, including obtaining an Activity License, a prior Visa to ensure compliance with local regulations. This procedure verifies that the business project complies with the operational criteria set by the city council and/or the regional government regarding home help services. The company must submit the application to the relevant delegation along with an explanatory report of the activity to be carried out, an economic-financial study, a proposed staff project, and the statutes of the owning entity. Finally, an administrative authorization from the regional government is also required: provider organisations must present additional documentation, such as the Register of Social Action and Social Services Entities (ibid.).

In Italy, two main in-kind services are accessible for long-term care : ADI (*Assistenza Domiciliare Integrata*) and SAD (*Servizio di Assistenza Domiciliare*) (Diodati, 2022). ADI offers free weekly hours of nursing care funded by the NHS and provided by local health units (*Aziende Sanitarie Locali*) managed by the regions. It is the only public healthcare service for dependent adults living at home. To access ADI, citizens must obtain a disability certificate, with the service’s intensity and duration depending on the disability assessment. However, coverage varies by region, and it’s estimated that ADI reaches only one-third of those needing daily care, despite the number of beneficiaries doubling since its inception. On average, ADI provides 18 hours of care per older person annually, typically for two to three months following hospital discharge (ibid.). SAD, on the other hand, corresponds to a social assistance provided by municipalities. Citizens apply for SAD through municipal social services, which evaluate and oversee the service. SAD offers help with activities like cooking and housework, with beneficiaries sharing the costs, which vary based on income and local regulations. Each territory provides a different model in terms of number and kind of

services provided, qualifications of the staff. Services in kind like ADI and SAD provide only a very modest coverage of the population (Pais and Bonifacio, 2024; Costa, 2012). This limited public service intervention is often provided by social cooperatives that participate in public tenders and have only health sector professionals (Pais and Bonifacio, 2024).

2.3. Varieties of cash transfers

In all the countries under study, the ideology of the “free choice”(Morel, 2007) led the welfare state to develop models of choice and also cash transfers, explicitly seen as a way for dependent people to exert their agency. These cash transfers have nevertheless been very differentially organised. For example, in Denmark, since 2003, all people living in their own homes who qualify for publicly funded home help or practical services such as cleaning have the legal right to choose between at least two publicly funded service providers, be they private or public. They can also choose to select their own personal assistant with a prepaid voucher or the different cash-for-care schemes under the free choice model (Larsen and Ilsoe, 2024). The cash transfers available to pay extra-family work existing in the different countries are nevertheless associated with different conditions, which are explicated in the following sections. Ireland is not developed in this section since care is mainly commissioned and provided and the cash for care benefits (Carer’s Allowance or Carer’s Benefit) are mostly targeting family members. There is some use of personal budgets with tends to be for those with a disability rather than care for older people. Mary Daly underlines indeed that “*Traditionally in Ireland, older people have been cared for at home by family and community. This has rendered public provision somewhat residual and under-developed, Ireland, though, has a history of providing financial support for care at home – in fact Ireland was the first country in Europe to introduce a cash payment for care. This long-term pattern of incentivising the supply of informal care is deeply ingrained in the Irish system*” (Daly, 2018).

We are distinguishing between three types of cash transfers: targeted, regulated and traced direct benefits, which are directly received by the beneficiaries and which usages are regulated and controlled, less regulated cash benefits and tax breaks, which imply indirect payments (Carbonnier and Morel, 2015).

Table 7: Conditions and levels of long-term care benefits which could be used for extra familial paid care workers

	Authorities in charge	Eligibility criteria	Conditions
The Netherlands (WMO)	Health insurances	Theoretically all citizens covered by the health insurance—depending on needs	Means tested, co-payment, depending on the municipalities

Denmark	Local authorities	Universal depending needs	– on	Local authorities decide the level of home help and practical services. Co-payment limited to meals on wheels.
France (APA and PCH)	<i>Départements</i>	Universal depending needs	– on	National rules implemented by the départements, co-payment income modulated
Italy (IDA)	Local health medical commissions	Universal depending needs	– on	Co-payment of SAD, income modulated and depending on local authorities' policies but limited availability
Spain (Economic benefits)	Regional governments	Universal depending needs	– on	Co-payment with a level depending on local authorities, limited availability
Ireland	Health Service Executive	Universal depending needs	– on	Care is commissioned and provided but there is some use of personal budgets with tends to be for those with a disability rather than care for older people

2.4. Targeted regulated and traced direct benefits

In Denmark, France and at some point, in Spain, cash for care scheme with a high degree of regulations and tracing have been introduced, and sometimes linked to vouchers; these benefits are dedicated to care and can only be used for such activities.

In Denmark, different regulated and traced cash-for-care benefits linked to extra-family care have been introduced and they do not systematically arrive in the pockets of the beneficiaries since they can also be distributed to providers or approved entity:

- The BPA scheme (Citizen-Administered Disability Assistance), established in 2009, is managed and financed by local governments and supports disabled adults or individuals with significant physical and mental impairments by covering the cost of employing a personal care assistant. The recipient must be able to act as a manager and employer, unless this responsibility is delegated to a private company, NGO, or approved relative.
- The cash-for-care allowance introduced in 2003 under the free choice care model allows recipients, if they qualify for public-funded home help or practical services, to choose to receive a prepaid care voucher or a cash allowance for their preferred provider.
- The contact and companion assistant scheme requires local authorities to provide a personal companion for disabled adults who cannot travel alone, offering at least 15 hours of assistance per month. Recipients can choose between an appointed assistant or a cash allowance to hire their own, subject to local authority approval. The benefit is available only to severely disabled adults who cannot travel alone, this lifelong scheme continues into old age. The assistant generally cannot be someone

with a close personal relationship to the recipient. When an eligible older or disabled person selects their own publicly funded personal assistant, local authorities must approve the appointment, though the specific eligibility criteria can differ by locality (Larsen and Ilsoe, 2024).

In France, APA, PCH and social assistance can pay for services in kind, but also through cash-for-care schemes, which can be distributed according to local authorities' policies, directly to people or through a voucher, the "universal service employment cheque" scheme, known as Cesu. This voucher can be used to make payments for buying the service of service providers, for employing a worker and both. The funding institution can choose between these different options. The voucher has been increasingly used with the objective to control the usages of public money, but the *départements* have the choice to use it or not. Some *départements* authorities (like the *département* of Loire Atlantique) distributes it only for paying workers employed by families, while others distribute it only for paying the providers (like the *département* of Seine Saint Denis (Petiau, 2023)). In the *département* of Loire Atlantique, the providers are directly paid by the *département*. When dependent people receive a voucher in order to directly employ a worker with it, they are then obliged to declare them and enter the Cesu system. When households employ workers through the Cesu, the system calculates the amount of the social contributions to pay and operates this payment. The system sends beneficiaries a message when the paid hourly rates are not respecting the collective agreements. The system also automatically deducts social security contributions to finance the paid holidays.

In Spain, the law prioritises public services over privates, since economic benefits linked to the acquisition of a service are intended for cases where it is impossible to access an appropriate public service (Godino and Molina, 2024; Cabrero and Gallego, 2012, p.209). The amount of the economic benefits can vary significantly depending on the region. Three different benefits directly linked to the production of care (cash-for-care) exist, giving the possibility to pay the services of private companies, hire professional caregivers, or even compensate informal caregivers (within the family). The central administration finances the common basic coverage and the regions also contribute. A co-payment in accordance with beneficiaries' income and wealth is also planned (ibid.) Only the following two types of cash benefits are therefore available for extra family members care workers and could potentially support the platform economy:

- **Economic benefit for personal assistance** : This benefit is designed to help cover the costs of hiring a personal assistant who, under the guidance of the person with a disability, assists with daily tasks and/or provides support for access to employment, education, leisure, and social participation. Previously limited to individuals with severe dependency (degree III) until 2012, this benefit is now available to all levels of dependency (Godino and Molina, 2024). The person providing assistance must be over 18 years old, legally reside in Spain, meet the necessary conditions to offer personal assistance services, and comply with Social Security registration and

affiliation requirements when the assistance is provided under a service contract (ibid.).

- **Economic benefit linked to the acquisition of a service** : This benefit is intended for situations where appropriate public services are not accessible to the dependent person. Beneficiaries are free to choose their professional service providers, which may include home help, day centers, night centers, as outlined in the Individualized Care Plan (PIA) according to the level of dependency. The funds received are strictly for the purpose of contracting these services, and the amount can vary significantly based on the region, the degree of dependency, and the financial capacity of the individual. In these cases, service providers must be accredited by the respective city or region (ibid.).

In Italy, regional subsidies for home care include various types of care vouchers, such as *assegni di cura*, *buoni badanti*, and *contributo per assistenti familiari*, which are contingent upon the regular employment of home care workers with valid residency permits. They benefit a small segment of the population (Pais and Bonifacio, 2024). These vouchers can be combined with the primary cash benefit, the *Indennità di accompagnamento* (IDA). Additionally, they may be paired with programs for training home care workers, family caregiver support desks, respite care services, and mediation between families and care workers (ibid.). However, the number of beneficiaries, the benefit amounts, and the criteria for assessing applicants' financial conditions vary widely, not only between regions but also within them. In some areas, where priority is given to low-income applicants, funding may be exhausted before all eligible applicants are served, leading to uncertainty about the subsidy's duration. In other regions, the small size of the vouchers is a significant issue, as they provide only minimal support unless accompanied by substantial tax incentives for hiring care workers. Currently, only about half of Italy's regions offer these vouchers specifically for home care workers.

2.5. Less regulated direct cash benefits

Netherlands and Italy have developed direct cash transfers which usages are less regulated and giving sometimes the possibilities to use them on the grey or black markets. In the Netherlands, people who want to organize their own support and domestic help under the Social Support Act (WMO) can apply to their municipality for a personal budget (*persoonsgebonden budget*, PGB), with the same eligibility criteria as for in-kind benefits. The municipality decides on eligibility and finances the personal budget from the municipal budget⁴. With the PGB, people can hire and pay their own caregivers. These caregivers can be relatives or other people from their social network. A contract describing the care to be provided and a budget plan are mandatory when using a personal budget. This contract is submitted to the Social Insurance Bank (SVB), which administers the personal budget. According to Kelder and de Vaan, "*municipalities have certain reservations about the personal budget scheme, because it is more prone to fraud and it is also more difficult to*

⁴ A person can receive both a personal budget and in-kind services under the WMO.

control the quality of the care that is provided. They therefore apply stricter rules to the budget. This has resulted in fewer clients being deemed eligible for the scheme” (Kelders and De Vaan, 2018).

In Italy, the main social program for long-term care is the national cash benefit system regulated by the central government and distributed by the National Institute for Social Security, known as IDA (*Indennità di accompagnamento*). Eligibility for IDA is determined by local health commissions, which assess whether people are long-term dependent and do not take into account age or economic status. This flat-rate financial support, which is not tied to in-kind services, is not graduated according to different care needs. It is freely available and there is no public control over its use. Since the end of the 1990's, the coverage of older people by IDA increased while residential care and home care in-kind services did not. This has encouraged the development of an undeclared market composed mainly of migrant women (Pais and Bonifacio, 2024; Costa, 2012). In addition to IDA, regional authorities have provided additional subsidies to dependent older adults and families through the *Fondo nazionale per la non autosufficienza*, regional programs, and the European Social Funds (ESF). While these cash benefits initially helped Italian regions manage population aging, their costs have surged over the past thirty years. The decentralization of services, coupled with economic crises and austerity measures, has increased pressures on regions and municipalities, exacerbating disparities between wealthier Northern regions and poorer Southern. No formal restrictions are posed to beneficiaries in the usage of the subsidy. For this reason, IDA has been considered as fostering the irregular employment of home care workers (Pais and Bonifacio, 2024; Van Hooren, 2012).

2.6. Tax breaks

With the exception of Spain, all the ORIGAMI countries have income tax breaks supporting the usage of declared home care and in some cases also household services. These instruments have been considered as encouraging a (semi-)formalisation of home care and household services (Jaehrling, 2020). They are crucial for home services platforms, since they are in many cases connected to weaker regulatory tools than direct benefits. While French tax breaks are the most generous (it covers 50% of expenses and is accessible to all households, including inactive individuals) and finance both home care or household workers employed by families and by service providers, the Danish tax break can be received only when paying the services of a provider organisation. Like in France, the Italian one is accessible to all households employing a worker. In Denmark, the tax deduction for privately purchased cleaning services is only available if a receipt indicating the type of service purchased is provided, if payment is made through online banking, and a service agreement is signed between the client and the private company (ibid.).

In France, the income tax break benefit has played a key role in developing personal and household services since 1991 (Guiraudon and Ledoux, 2015). This tax break is available to all households employing a workers or paying the services of a provider organisation, with

higher thresholds for elderly and disabled people. Since the introduction of an immediate advance mechanism for tax credits in 2022, service providers can directly receive the 50% of the tax credit and the client pay only 50% of the price. Without explicitly presenting it as such, the demand-driven tax credit has been transformed into a supply-driven state grant (Ledoux *et al.*, 2024). It has led to concerns about fraud, with service providers exploiting the system by declaring services they hadn't performed. Additionally, VAT reduced rates also apply to declared providers and specific services, especially for the older and disabled (*ibid.*). When households use the income tax break to pay the employment of a worker, a formal employment relation has to exist. When they use it to pay the services of an organisation providing household services, this has to be declared. When they use it for paying home assistance and care for older and dependent people, they can only buy the services of an authorised organisation (for the providers).

In the Netherlands and Ireland, specific tax breaks exist for older and disabled people. In the Netherlands, to be eligible for a deduction for care expenses, the client must have a medical indication, the care received must not be covered by any of the other care acts, and clients must provide proof of payment with the date of care received, the amount of the cost, and the name and address of the care provider. This care provider can be anyone (public or private home care, family members) as long as an agreement is in place and proof of billing is provided (Hesselink and Been, 2024). In Ireland, tax relief on the costs associated with employing a carer for a family member is available, allowing families to recoup some of the costs of employing a carer provided by an agency. Some conditions include that the person being cared for must be totally incapacitated throughout the tax year (apart from the first year in which a claim is made). The carer does not have to be employed for the full tax year. The provision extends only to care, and there is no tax relief available if the person hired is only performing housekeeper/domestic duties as a form of support.

3. Regulatory instruments for home care / cleaning services

As financial instruments for home care are fragmented, one of the central questions regarding regulatory instruments for home care is whether they are reproducing the fragmentation associated to the financial instruments and to what extent they are able to go beyond it and to cover the entire work configuration. If there are some loopholes, the platforms for care and domestic services could use them. The regulatory tools identified here are the following: market entry, price regulation, quality regulation, and labour, employment and immigration regulation.

3.1. Entry on the market

To analyse the regulations on market entry, three situations have to be distinguished: (1) provider organizations producing home care, (2) producing household services, and (3) workers employed by households. For all three types of situations, it is crucial to determine

whether the regulations concern only services and work directly and automatically supported by the welfare state or all types of services. Here we distinguish between services that are explicitly supported by the welfare state, through in kind services or cash transfers and we contrast them with services that are not automatically subsidized by the welfare state.

According to the ORIGAMI reports, Denmark, the Netherlands and France have the most comprehensive and inclusive approval instruments, as rules apply to all providers (for-profit and non-profit organizations) of home care and domestic services.

Table 8: Approval policies on the different segments of the home care and household services markets for older and disabled people

	(1) Approval of home care providers...		(2) Approval of providers of household services...		(3) Approval of workers employed by families...	
	...subsidised by welfare policies	... <u>NOT</u> automatically subsidised by welfare policies ⁵	...subsidised by welfare policies	... <u>NOT</u> automatically subsidised by welfare policies ⁶	...subsidised by the welfare state	... <u>NOT</u> automatically subsidised by the welfare state
Danemark	x strong	x strong	x strong		x	
The Netherlands	x strong	x strong	x weak (Should be registered to the chamber of commerce + Certificate of Conduct for the workers)	x weak (Should be registered to the chamber of commerce + Certificate of Conduct for the workers)	Necessity to obtain a certificate of conduct	Necessity to obtain a certificate of conduct
France	x strong	x strong	x weak	x weak		
Ireland	x strong		x weak			
Italy	x strong					
Spain	x strong	x strong	x strong	x strong	Necessity to respect certain conditions	



The situation does not exist



Absence of entry on the market regulation

In Denmark, special conditions apply to publicly subsidized private companies that offer their home help or cleaning services to older or disabled adults. These conditions have become stricter in recent years (Mailand and Larsen, 2020). Some of the new legal requirements, which came into force in 2017, include the requirement that all private care providers are legally obliged to document that they have no debts of more than DKK 50,000 to any public authority and that they are able to provide the local authority with a bank guarantee, annual tax returns for the last three years and subsequently annually revised budgets (Larsen and Ilsoe, 2024). Most local authorities set local standards for public and private care providers and their staff, with considerable variation in the different

⁵ We do not count here tax breaks

⁶ We do not count here tax breaks

requirements between municipalities. The standards may relate to qualifications, (language) skills, criminal record checks, etc (ibid.). Non-subsidized companies providing home help to older or disabled adults must also be approved by the local authority and must comply with similar conditions as publicly subsidized care providers. However, these regulations do not apply to private, for-profit cleaning companies that are not publicly subsidized (ibid.). In situations where an older person or a disabled adult opt for recruiting their own personal care assistant under the free choice scheme, the local authority will have to approve the appointment of the personal care assistant.

In France, *all* organizations involved in the production of home assistance and care to older people having lost their autonomy and disabled people must either be *authorized* (for the providers) or have an *agrément* (for the proxies helping people to employ a worker and manage the employment relation). All organizations that provide household services must be registered in order for their clients to receive the tax benefits, but if the older people haven't lost their autonomy, the providers do not need to be authorised. While the approval regulation for the authorisation is strong, it is weaker for the agreement and declaration procedure. First, from 2023⁷, the *authorization procedure* is carried out through a tendering process, in which local authorities offer multi-year contracts with defined objectives and resources, known as *Contrats pluriannuels d'objectifs et de moyens (CPOM)*, for which service providers must submit bids. Those whose bids are accepted receive an authorization. In return for their commitments under the CPOM, service providers benefit from a multi-year visibility of the level of allowances, for their subsidised clients. All providers wanting to provide home assistance and care to elderly and disabled people, even those not subsidised by public expenditure have now to be authorized, this has been highly contested by private for-profit providers. The authorization is valid 15 years. Second, the *agreement procedure* applies to all proxy organizations (*mandataires*) which are not directly providing services but that help households to recruit a worker and manage the employment relationship. The agreement is valid 5 years. The procedure is facilitated if the organization has a private quality control⁸. Until 2023, the agreement procedure required the organization to have a physical local. A new rule in 2023 suppressed this requirement, making it thus easier for care platforms to enter the market through the proxy scheme. Indeed, this reform was explicitly justified as being favourable to digital platforms (Ledoux *et al.*, 2024). This change might accelerate the development of care platforms playing the role of proxies. Beyond this, in France, all personal assistants must be declared and respect a national collective agreement, but they do not need to be certified or authorized if they do not provide medical assistance.

In the Netherlands, 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. Home care workers who provide medical

⁷ This change was adopted through a 2015 law

⁸ <https://entreprendre.service-public.fr/vosdroits/F23633>

assistance must have a certain level of education. Both home care workers and cleaners must obtain a certificate of good conduct (VOG) to ensure they have no criminal record that would disqualify them from working with vulnerable populations (Hesselink and Been, 2024).

In Ireland, the HSE acts as both provider and commissioner of publicly funded home care services and oversees the delivery of the services it provides or procures. While the regulation towards publicly subsidised home care services is strong, there is currently no statutory regulation of private home care or home support services (Murphy, 2024). Providers supported by HSE funding need an Authorization Scheme (AS). It sets out the service specifications for home support service providers. Each applicant organization must demonstrate that it can meet the standards set out in order to be successful in the procurement process. Private and not-for-profit/voluntary sector providers must demonstrate their ability to respect certain principles and rules as: Principles of Service Delivery; Communication; Complaints; Consent; Assessment of Care Needs; Safeguarding & Protection of Service Users; Home Support Care Plan; Medication Management; Financial Procedures; Training and Development; Supervision of Staff; Health & Safety; Key Performance Indicators. The licensing system requires that workers positions be filled through open competition, which includes a face-to-face interview and an assessment of the candidate's previous experience. Care workers are expected to provide two written references, one of which must be from their most recent employer, and the potential new employer is expected to follow up with a phone call to verify these details before appointing a candidate to a position. The identity of the workers must also be verified through a process known as *Garda Vetting*, which effectively means that a police clearance certificate is obtained for each worker. Verification of the qualifications and training claimed must be undertaken. The ability to communicate effectively in English is also required. The employer must ensure that the worker has a valid work permit. The service provider must have contingency plans in place in the event that a worker does not turn up for a scheduled job in a client's home. Contingency arrangements should be agreed and documented in each service user's Home Support Care Plan, including the service user's priority rating and the service provider's emergency contact details. The documentation will state that the provider must have a formal contract of employment, including a probationary period, with each of its employees and must provide each employee with a written job description. The HSE has introduced rules on the training of providers' staff. Before starting their first assignment, workers are expected to have completed (at least) 20 hours of training, including 5 hours of practical application of theory in a classroom setting. A new worker must be supervised and shadowed for the first 8 hours of direct client work before being allowed to work alone. It is also expected that a plan is in place to ensure that home support workers maintain competencies and skills to fulfil their role in meeting the needs of clients. For staff who do not already hold a qualification, it is expected that they have, as a minimum, received appropriate induction, manual handling and people handling training, including lifting training and certification in infection control. All these regulations do not apply to non-subsidized

providers, meaning that a very weak regulated segment in which clients pay providers out-of-pocket, often to top up hours paid for by the HSE lay on the regulated segment. This less regulated segment is supported by the tax relief and for which few barriers to entry exist (Mercille and Lolich, 2024). According to Mercille and Lolich, private providers currently would derive about at least 25% of their income from the out-of-pocket market (ibid.). There are no separate or specific regulations in regards to regulations around intermediary providers either (Murphy, 2024).

In Italy and Spain, providers delivering home care are authorised but remain rare (Godino and Molina, 2024). In Spain, both the Dependency Law and regional regulations stipulate that care services can be provided not only by the public administration but also through the development of business activities, professional services, or by a non-profit entity. However, this activity must be accredited by the competent Directorate-General in each region or city. For this, there are three general conditions for a private company to provide home help services (Prados, 2015). The “Territorial Council of Social Services and the System for Autonomy and Care for Dependents” composed of the Minister and the Heads of the Social Services and Dependency Departments of each of the Regional Governments, establishes common accreditation criteria (ibid.). The first criteria were established in 2008 and have been slightly modified several times. Today, three conditions can be underlined. First, the company requires an Activity, Opening, and Operating License issued by the city council where it intends to set up. Obtaining this license can take between 3 and 12 months (ibid.). Secondly, the company needs a prior visa, which verifies that the business project complies with the operational criteria established by the city council and/or regional government regarding home help services (ibid.). The company must submit the application with an explanatory report of the activity to be carried out, an economic-financial study, a proposed personnel project and the statutes of the owning entity. Finally, the company must obtain an administrative authorization, for which it must present additional documentation, such as the Register of Social Action and Social Services Entities. In the case of dependent individuals who receive an economic benefit for personal assistance, the person responsible for providing this assistance must meet certain requirements (be over 18 years old; legally reside in Spain; meet the suitability conditions for providing personal assistance services; and demonstrate compliance with the obligations of affiliation and registration in the corresponding Social Security Regime when the relationship with the dependent person is based on a service provision contract) (ibid.).

Concerning Italy, few regions have created registers of qualified workers, a system in which care vouchers are part of a broader program that includes support for families in finding a worker and managing the employment relationship (see p. 2.3). Emilia-Romagna, for example, has opted for this model, which involves institutional management of workers employed by families. Social services can propose workers from the list, help families with administrative tasks, and mediate between employers and workers (Pais and Bonifacio, 2024). In some areas, local health workers may be part of public training programs for families and workers (ibid.). To be included in the registers, workers must generally have a

diploma, no criminal convictions or pending criminal charges, and, for foreigners, a visa and adequate knowledge of the Italian language. Workers must also have experience as home care workers; otherwise, they must attend a training program, which can also be part of the register. Nevertheless, these initiatives remain quite rare and of limited use (ibid.).

3.2. Quality control

Quality controls are also different along the different segments of the home care and household services markets.

Table 9: Quality policies on the different segments of the home care and household services markets for older and disabled people

	(1) Quality control of home care providers...		(2) Quality control of providers of household services...		(3) Quality control of workers employed by families...	
	...subsidised by welfare policies	...NOT automatically subsidised by welfare policies ⁹	...subsidised by welfare policies	...NOT automatically subsidised by welfare policies ¹⁰	...subsidised by the welfare state	...NOT automatically subsidised by the welfare state
Denmark	strong	strong	strong	strong		
Netherlands	strong	strong				
France	weak	weak	weak	weak		
Ireland	strong		weak			
Italy	strong					
Spain	strong	strong	strong	strong		

	The situation does not exist
	Absence of quality regulation

In Denmark, the quality control of service providers is strong. The Danish Patient Safety Authority also regularly inspects the quality of care of both publicly provided, publicly subsidized and procured private home help, cleaning services and institutional care (ibid.). The Danish Patient Safety Authority also has a duty to carry out unannounced inspections to ensure that care standards are enforced according to the health and social care regulations regarding documentation, quality of care, etc. (ibid.). In addition, the Danish Patient Safety Authority is required by law to write an inspection report for each unannounced visit to public or private care providers. Individual citizens also have the opportunity to contact the Danish Patient Safety Authority if they suspect a possible violation of the standards of care, and if the Danish Patient Safety Authority considers the request to be valid, it will open an inspection case. In the case of suspected violations, the Danish Patient Safety Authority is legally obliged to inform the municipality and its municipal council. It is then the responsibility of the municipality to ensure that the violation is

⁹ We do not count here less visible subsidies coming from tax breaks

¹⁰ We do not count here less visible subsidies coming from tax breaks

remedied (ibid.). Beyond this, all Danish municipalities are obliged to regularly inspect the care services provided to older people and disabled adults by both public and private care providers offering home help, reablement and retraining services, cleaning services or institutional care (Larsen and Ilsoe, 2024). Their role is to ensure that the rules and regulations are enforced according to the local quality of care standards set by each municipality. The inspections include at least one unannounced visit per year by the local authorities, and it is the responsibility of the municipality to follow up on any cases and remedy any violations found (ibid.). All Danish municipalities are also required by law to develop and publish their quality standards and public tenders on their websites and their enforcement policy for public tenders, including the procedures they use for inspections and follow-up of potential violations, and to evaluate their enforcement policy and quality of care standards at least once a year and adjust them accordingly (ibid.).

In the Netherlands, 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. For the cleaning sector, no specific organization oversees the quality of services, but providers are expected to adhere to general labour and consumer protection laws (Hesselink and Been, 2024).

In France, after the introduction of the new licensing procedure in 2015, the quality regulation of home care providers was transferred to the *départements*. The ability to really evaluate the quality of services depends on the capacity of these authorities to do so. Financial controls, controls on the execution of services have been reinforced, and *départements* may also have requirements concerning the qualifications of workers. In the case of the agreement procedure, the quality controls are weaker and also rely on private quality systems. In the absence of real ex post quality control with the agreement procedure, a National Quality Charter for personal services has been developed by the Ministry for the Economy and Finance and the personal services industry has developed its own service certification as a voluntary process supposed to guarantee customers a recognised level of quality. The declaration needed for accessing the tax breaks and through which cleaning services operate does not imply quality controls.

In Spain, the Region and the Municipalities are responsible for the evaluation of the quality of providers of in-kind services, following the rules developed by the Territorial Council of Social Services and the System of Autonomy and Care for Dependent Persons. It established common minimum standards aimed at ensuring the quality of services received by dependent persons and a minimum ratio of first level direct care personnel in home help services (Godino and Molina, 2024). As in Spain, the quality of in-kind services in Italy is quite regulated.

In Ireland, the service providers must provide the HSE clear contact details so that families can contact them if a worker is unable to come to work. They must also provide a list of all

missed calls/visits and the reasons for them when submitting monthly invoices for payment (Murphy, 2024). They must self-declare the percentage of their staff working on HSE contracts who are new to home care or have less than one year's experience, as well as the percentage of existing home care staff who are unqualified. Service providers are required to complete a self-declaration on a quarterly basis to accompany their monthly invoice submitted to the HSE for payment. The HSE has the right to audit and quality assure the self-declaration returns and reserves the right to inspect the services provided. These measures demonstrate the extent to which the state is attempting to increase the professionalization aspect of home care work and ensure quality of service to clients (ibid.).

3.3. Price regulation

As for approval and quality, prices are differentially regulated across the different segments of the home care and household services sub sectors.

Table 10: Price regulation of the different segments of the home care and household services markets for older and disabled people

	(1) Price regulation of home care providers...		(2) Price regulation of providers of household services...		(3) Price regulation of workers employed by families...	
	...subsidised by welfare policies	...NOT automatically subsidised by welfare policies ¹¹	...subsidised by welfare policies	...NOT automatically subsidised by welfare policies ¹²	...subsidised by the welfare state	...NOT automatically subsidised by the welfare state
Denmark	x	Indirect (through employment regulations)	x	Indirect (through employment regulations)	x	Inexistent
The Netherlands	x	Indirect (through employment regulations)	Inexistent	Indirect (through employment regulations)	Quasi-inexistent	Inexistent

¹¹ We do not count here less visible subsidies coming from tax breaks

¹² We do not count here less visible subsidies coming from tax breaks

France	x (regulation of price evolution for the home assistance services authorized)	x (regulation of price evolution for the home assistance services authorized)	Indirect (through employment regulations)	Indirect (through employment regulations)	Indirect (through employment regulations)	Indirect (through employment regulations)
Ireland	x	Inexistent	x	Inexistent		Inexistent
Italy	x				Indirect (through employment regulations)	Indirect (through employment regulations)
Spain	x	Inexistent	x	Inexistent	x	Inexistent

 The situation does not exist

In France, the home help organizations that provide social assistance to poor families have their prices set by the *départements*. These organizations are non-profit organizations. The other home help organizations (for profit and non-profit), which provide services to older and disabled people under the authorization regime, have the increase of their prices regulated by the state¹³. For all of them, the prices cannot be below the national level of the APA, which has been fixed at €23.50 in 2024. In Spain, public administrations regulate the prices of public and subsidized home help services, although the price of these services varies by region. For example, the hourly rate in Andalusia is €15.45. In any case, the price varies within a range between €12 and €19 (Godino and Molina, 2024). In Denmark, Larsen and Ilsoe explain that the prices for public subsidised home help and practical tasks such as cleaning are set by the individual local authorities based on the estimated average costs for providing personal care and practical cleaning services outlined in the local care quality standards by the individual municipalities (Larsen and Ilsoe, 2024). These prices are typically publicly available. Cross-regional variations exist as to the prices listed by individual local authorities where there only is an upper statutory ceiling for meals on wheels regarding self-financing (ibid.). For example, in Hilleroed municipality, the listed prices for subcontracted cleaning services are €63 (468 DKK) per hour while the hourly rate is €68 (506 DKK) for subcontracted home help with a higher hourly rate for unsocial hours €92 (684 DKK) per hour (ibid.). Other local authorities such as Gulbergsund municipality operate with slightly different prices for subcontracted care and cleaning services €57 (423 DK per hour) with a higher hourly rate for unsocial hours (€73 (542 DKK) (ibid.). For non-subsidized care, the free-market forces are at play, and it is thus left to the negotiations between the care recipient and the individual private for-profit care provider (ibid.). However, most private for-

¹³ For example, in 2024 these prices may not increase by more than 5.95% compared to the previous year.

profit care providers list their prices on their websites with examples of hourly prices for cleaning ranging from €68– €115(510–860 DKK) per hours and hourly prices for home help varying between €50– €80 (375 DKK– 600 DKK) depending on the private cleaning or home help company (ibid.). In the Netherlands, 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 (Hesselink and Been, 2024). In Ireland, for the in-kind services directly supported by the HSE, the services are free of charge and directly paid by the HSE, the services been paid through tenders which tariffs are fixed by the HSE. Providers are not permitted to charge rates (or additional fees or charges) that are higher than that agreed with the HSE (Murphy, 2024). Parallel to this administrated quasi-market, on the market in which clients pay providers out-of-pocket, the prices are unregulated (Mercille and Lolich, 2024). In Italy, the existence of a collective agreement applicable to all workers employed by families theoretically constraints families (Borelli, 2020).

Additionally, to these regulations, in many of the countries under the ORIGAMI scrutiny, placement agencies are regulated. Some home care and cleaning platforms, like 125 placement agencies in Spain (Godino and Molina, 2024) and Helpling in the Netherlands, have adopted the forms of the placement agencies (Hesselink and Been, 2024). In some of these countries, like Spain, governments have also began to regulate the platform economy at an intersectoral level (Godino and Molina, 2024).

3.4. Migration regulatory instruments

Migration regulations interfere with care regimes (Van Hooren, Apitzsch and Ledoux, 2019). The policy instruments interfering can be regularisation waves, measures easing the access to work for migrant home care and household services workers, rules around work permits. Facing staff shortages, some of the governments introduced regularisation waves of undocumented migrants. It has been the case in Italy (2020), Spain (2022), Ireland (2022). These have constituted a means to formalise the informal market. Different governments also introduced in the recent years measures to ease migrant home care workers access to work like in Denmark, France, Ireland. Nevertheless, in some countries, like Italy, obtaining a job as a care worker in a care provider organisation might be difficult for migrants, if professional qualification or good level of linguistic skills are required.

Italy's migration regime appears to be particularly restrictive of legal channels for entry for work purposes, while being quite tolerant of undocumented migrants (Van Hooren, 2012). The use of undocumented migrants subsidised by the IDA is the easier solution for households which face limited institutional and in-kind services. This creates a flexible and cheap labour force for low-skilled, low-paid domestic work. (Pais and Bonifacio, 2024; Borelli, 2020). Where the work permit system operates on an "employer-led" basis, such as in Ireland, black market forms on home care/household services could be encouraged in

situations where it is difficult for family carers to employ a home care worker to provide care in the home independently of organizations (Murphy, 2024).

3.5. Home care and household services regulatory regimes for older and disabled persons

The combination of the different regulations concerning the entry on the market, the quality and price regulations brings to consider Denmark, Spain and France to have the more comprehensive and inclusive regulatory tools, but with still some weaknesses (see table 11): in all of these countries, the regulatory tools applying to workers employed by families are weak. In the Netherlands and Denmark, household services not automatically subsidised by the welfare state are subjected to weaker regulatory tools, as in Ireland for all providers not subsidized. In Italy, the direct employment segment is less regulated than in France, since the only rule really binding concerns the hourly price.

Table 11: Home care and household services regulatory regimes for older and disabled persons

	(1) Regulatory regimes of home care providers...		(2) Regulatory regimes of providers of household services...		(3) Regulatory regimes for workers employed by families...	
	...subsidised by welfare policies	...NOT automatically subsidised by welfare policies ¹⁴	...subsidised by welfare policies	...NOT automatically subsidised by welfare policies ¹⁵	...subsidised by the welfare state	...NOT automatically subsidised by the welfare state
Denmark	strong	strong	strong	weak	weak	inexistent
France	strong	strong	weak	weak	weak	weak
Spain	strong	strong	strong	strong	weak	inexistent
The Netherlands	strong	strong	weak	weak	inexistent	inexistent
Ireland	strong	inexistent	weak	inexistent		inexistent
Italy	strong				quasi-inexistent	quasi-inexistent

 The situation does not exist

¹⁴ We do not count here less visible subsidies coming from tax breaks

¹⁵ We do not count here less visible subsidies coming from tax breaks

The combination of this table with table 12 which is presented below gives the opportunity to understand how crossing the regulatory and financial tools contributes to support different architectures of markets, in which home care platforms can enter

Table 12: Percentage of Public long-term care spending on home care and cash benefits as percentage of GDP

	Resources dedicated to home care for dependent people
Denmark	IMPORTANT with also important resources dedicated to institutional care
The Netherlands	
Italy	IMPORTANT without important resources put on institutional care
France	LIMITED with also important resources dedicated to institutional care
Ireland	LIMITED without important resources put on institutional care
Spain	SCARCE without important resources put on institutional care

We can expect home care and service platforms to take different forms depending on the national institutional framework (Thelen, 2018). Home care platforms have been considered as contributing to formalising employment relationships in liberal economies and fostering more informal work in more formal labour markets (Pulignano *et al.*, 2023). We hypothesise that home care and household services platforms may also take different forms depending on the types of financial and regulatory instruments and that some differences are to be seen even in the same type of economies. We also hypothesise that :

1. If they have access to financial instruments, we can imagine that home care and household services platforms will try to meet the conditions attached to these instruments in order to have access to them.
2. They will try to choose the less demanding regulatory instruments to minimize their costs and exploit the loopholes in the regulatory instruments where possible.

In Denmark, since regulatory instruments for publicly subsidized home help and cleaning services are strong, one might also expect difficulties for platforms to enter this segment, as they would have to comply with all the rules. They could nevertheless develop in the loopholes left by the welfare state, especially in the unsubsidised segments.

In the Netherlands, since the welfare state has built a strong frontier between household services and home care, one could expect the digital platforms to have reproduced this separation and to develop mostly in the household services and home employment, where the regulatory tools are weaker than in the home care services.

In Italy, one might expect a number of home care and household platforms to develop with the financial support of the welfare state, bringing individuals use the IDA scheme to pay the services of platforms or employ home care workers, since nor rules are related to the use of the IDA Scheme.

In France, since the system of providers is subject to the authorization procedure, platforms reaching elderly and disabled adults may have incentives to choose the *mandataire* form or to act as marketplaces between workers and employers in order to have access to the tax credit and the home care allowance. We can imagine that they will rely on the

institutionalized form of employment by families. Since the frontier between home care and household services has been blurred by the French welfare state, one could expect to find platforms proposing both domestic work and personal care.

In Ireland, the welfare state subsidies go through a providing model, one can expect that platforms will operate with or on a provider basis when supported by the welfare state, but that they will also develop out of the support of the welfare state since the public expenses in the sector are still limited.

In Spain, since the public expenses dedicated to home care and household services are scarce and the regulatory instruments for providers strong, one can expect the home care and household services platforms to develop without the support of welfare spending and to rely mostly on family employment, declared or undeclared.

4. Conclusions

This comparative report has shown the general tendency to a growing trend of marketisation and privatization of care organized by European welfare states, in countries with different demographic situations as the importance of older people in terms of percentage of the population and public spending in social care. It also underlines the diversity of policies in the home sub-sector, with different efforts put on public spending in home services and work, as well as different regulatory policy instruments. As most digital platforms are private actors, in most of the countries, they can benefit in the home sub-sector from less visible tax breaks instruments (except in the Spanish case), but at different levels. They probably find their place in the segments left accessible for them in these architectures of the markets. This is analyzed more into details in the ORIGAMI report 3.1.

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