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# The Limits of State Control in Regulating Live-In Care Work in The Netherlands

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## Abstract

Across Europe, migrant live-in care workers from Central and Eastern Europe play an increasingly important role in long-term care systems. These arrangements are often associated with precarious working conditions, including long hours, low pay, and blurred boundaries between work and private life. The Netherlands is sometimes considered an exception, as generous cash-for-care subsidies combined with relatively strict regulation suggest that live-in care workers should be protected from such conditions. Yet reports of exploitation continue to emerge. This article examines how precarious working conditions persist despite extensive regulation. Drawing on a qualitative study of Slovak migrant live-in care workers and intermediaries operating between Slovakia and the Netherlands, the analysis explores how care arrangements are organised and governed in practice. The findings show that formal compliance with labour regulations often coexists with expectations of near-constant availability. Intermediaries play a central role in structuring these arrangements, shaping recruitment, contracts, and mobility between households and workers. Using a framework that examines the interaction between funding, regulation, information, and enforcement in welfare markets, the article demonstrates how generous public funding and strong regulation can still produce regulatory blind spots. By focusing on the everyday experiences of migrant workers and the role of intermediaries, the study contributes to debates on the governance of migrant care labour and the regulation of household-based care markets.

## Keywords

cash-for-care; labour regulation; live-in care; migrant care workers; welfare markets

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## 1. Introduction

Across Europe, migrant live-in care workers from Central and Eastern Europe have become central to the provision of care for older people. In countries such as Italy, Austria, and Germany, they are structurally embedded in household-based care arrangements, often under ambiguous employment and residency conditions (Aulenbacher et al., 2024; Da Roit & Le Bihan, 2010; Trukeschitz et al., 2022). These arrangements are closely linked to the marketization of care (Farris & Marchetti, 2017; Hoppania et al., 2024) through cash-for-care schemes that allow families to organise care themselves by combining public benefits with private resources (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007). Research has consistently shown that live-in care work financed through cash-for-care schemes tends to entail precarious working conditions, including long hours, low pay, informal employment, and blurred boundaries between work and private life (Boccagni, 2017; Gábriel, 2020; Lutz & Palenga-Möllenbeck, 2010). Even in countries that have introduced specific regulations for migrant live-in care, these problems persist (Österle & Bauer, 2016; Sagmeister, 2024).

The Dutch system is sometimes presented as an exception within the European migrant care landscape. Alongside elaborate in-kind care provision, the Dutch cash-for-care subsidy is highly generous and more strictly regulated than in other countries. Previous research has suggested that, as a consequence, live-in migrant care workers receive at least the Dutch minimum wage and work within regulated hours (Böcker et al., 2021; Da Roit & Van Bochove, 2017). Yet journalistic investigations and our own fieldwork point to a more ambiguous reality. Reports describe workers who, on paper, work 40 hours, but in reality work day and night (Van Wanroij, 2024, 2025a, 2025b). How can such exploitative conditions persist despite a generous funding scheme and extensive regulation?

The dynamics of care marketization in practice are shaped by concrete policy choices (Farris & Marchetti, 2017; Hoppania et al., 2024; Ledoux et al., 2021; Shutes & Chiatti, 2012; Van Hooren, 2012). Building on Ledoux et al.'s (2021) three-dimensional typology of policy instruments, which highlights the role of funding, regulation and information in shaping welfare markets, we add a fourth dimension: enforcement, understood as the state's capacity to ensure that welfare market regulations are effectively implemented. Empirically, our analysis focuses on a case study of Slovak live-in care work in the Netherlands and draws on policy analysis, observations, and interviews with Slovak care workers, Slovak and Dutch intermediary agencies and Dutch regulators. We show that precariousness in live-in migrant care is both a consequence of weak enforcement and a systemic outcome of how states design and govern welfare markets. In this context, intermediary agencies can become active producers of semi-formal practices, using legal and organizational workarounds such as self-employment and sub-contracting to reconcile formal compliance with low wages and expectations of near-constant availability from care workers.

Hereafter, we situate live-in migrant care work within broader debates on welfare markets, outlining how financial, regulatory, informational, and enforcement instruments interact with the role of intermediary agencies and migrant care workers. Section 3 presents our research design and methods, detailing the multi-sited ethnographic approach connecting fieldwork in Slovakia and the Netherlands. Section 4 maps the Dutch policy instruments that govern live-in care, while Section 5 analyses how Slovak live-in care workers and Slovak and Dutch agencies navigate this institutional landscape in practice. In Section 6, we show how a lack of information and enforcement capacity limits Dutch state control of live-in migrant care

work. The conclusion draws out the broader implications for understanding the limits of state control in welfare markets and reflects on possible avenues for improving the regulation and protection of live-in migrant care workers.

## 2. Dynamics of Welfare Markets and Live-In Migrant Care Work in Europe

European long-term care systems are increasingly characterised by marketization, that is, the expansion of market mechanisms and consumer choice into domains previously dominated by public or family provision (Farris & Marchetti, 2017). This development has given rise to "welfare markets" (Ledoux et al., 2021), in which care is organised through complex interactions between state funding, private providers, and household demand, often across borders (Shutes & Chiatti, 2012; Van Hooren, 2012). Within these markets, live-in care has become a key organizational form, sustained by transnational intermediaries, subcontracting chains and organizational models designed to maximise flexibility, minimise statutory labour obligations, and diffuse responsibility for working conditions (Aulenbacher et al., 2024; Hoppania et al., 2024; Lutz & Palenga-Möllenbeck, 2010). Rather than emerging solely from regulatory gaps, the precariousness of live-in care is thus actively enabled by the institutional design of welfare markets themselves.

The conditions under which migrant live-in care workers are employed are closely shaped by policy instruments. In this article, we distinguish four key types of policy instruments. We apply Ledoux et al.'s (2021) three-dimensional typology of financial, regulatory, and informational policy instruments to the field of live-in care, adding a fourth dimension: enforcement, by which we mean the ability to monitor and enforce compliance. Hereafter, we elaborate on each of these instruments and how they shape live-in care work. Later, in section four below, we discuss each of these policy instruments in more detail in the Dutch context.

Financial instruments (most notably cash-for-care schemes) provide people in need of care with the financial means to organize care themselves (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007; Van Hooren, 2012). These schemes, now widespread in Europe, vary greatly in their generosity, from modest flat-rate benefits to highly substantial and graded subsidies. By allowing households to combine public subsidies with private resources, cash-for-care schemes create demand for live-in arrangements that would otherwise be unaffordable, thereby stimulating the recruitment of cheap migrant workers under flexible and often precarious conditions (Shutes & Chiatti, 2012; Van Hooren, 2012)

Cash-for-care benefits differ not only in their generosity but also in how strictly their use is regulated, ranging from complete freedom to tight rules on service organization and quality requirements (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007; Van Hooren, 2012). Other regulatory instruments include labour standards, collective agreements, migration regulations, and social protection rules. Where spending of cash-for-care benefits is unregulated, as in Italy or Germany, recipients often use subsidies to finance informal or irregular care arrangements, which are characterised by long hours, low pay and the absence of social protection (Gábriel, 2020; Lutz & Palenga-Möllenbeck, 2010; Van Hooren, 2012). In response, some countries have introduced tightened or supplemented regulations. For example, in 2007 Austria introduced a regulated supplement to its unregulated cash-for-care subsidy (Österle & Bauer, 2016; Schmidt et al., 2016). This means-tested supplement is conditional on formal engagement, through employment or based on a contract with a self-employed care worker (Schmidt et al., 2016). In practice, most households in Austria choose to engage a self-employed worker. Such constructions are often used in live-in care work.

They have been called "bogus self-employment," because the reality of live-in care work implies "directing and supervising the working activity in a manner incompatible with the independent status of self-employment" (Sagmeister, 2024, p. 122). Consequently, despite attempts to regulate live-in care work, the sector continues to be governed through regulatory grey zones (Schmidt et al., 2016).

Informational and enforcement instruments further shape how welfare markets operate in practice. By informational instruments we mean registration systems, reporting requirements, and administrative categories. The information dimension of welfare markets is not neutral. It shapes what becomes visible and actionable in policy, regulation, and public debate. Having information on what happens within welfare markets is a crucial step towards formalizing care work and improving working conditions (Daly et al., 2025). While some countries, such as Austria, keep formal registries of (self-employed) live-in care workers or the agencies that offer these services (Sagmeister, 2025), in many other countries live-in care remains poorly captured in statistics and administrative registers and there is consequently little knowledge to inform policy debates (Leiber et al., 2019).

Finally, by instruments of enforcement, we mean public authorities that attempt to monitor and enforce the implementation of regulations. Compliance may be enforced by labour or healthcare inspections, or tax audits. Yet it is complicated by the fact that care is delivered in private households, where authorities cannot simply enter for inspections, and often remains invisible to authorities. As a consequence, the extent to which informal practices are controlled and punished remains limited (Seiffarth, 2023). Enforcement is further complicated by transnational subcontracting chains, which fragment responsibility across agencies and jurisdictions and allow states to tolerate widespread irregularities while formally upholding protective regulations (Aulenbacher et al., 2021). In Germany, for instance, the persistent lack of effective enforcement in live-in care has led scholars to describe the state as complicit in maintaining an informal market (Lutz & Palenga-Möllenbeck, 2010).

Together, these four policy dimensions shape the dynamics of welfare markets and the working conditions of live-in carers. A key group of actors within these markets is intermediary agencies. They connect care workers and recipients, organize recruitment and cross-border mobility, and often shape the contractual form of employment. While agencies can, in principle, contribute to the formalization of employment and strengthen workers' bargaining position (Fudge & Hobden, 2018; Lobel, 2001), research in the European context more often highlights their role in reproducing precarious labour relations. Agencies frequently rely on (bogus) self-employment or subcontracting, which shift the risks of sickness, unemployment, and fluctuating demand onto workers and weaken their capacity for collective organization (Steiner et al., 2020; Uhde, 2016; Uhde & Ezzeddine, 2020). Care workers thus navigate labour markets in which their formal status as self-employed entrepreneurs coexists with strong dependency on agencies for access to clients, information, and legal compliance.

## 3. Research Design and Methods

This study combines a mapping of Dutch policy instruments with qualitative multi-sited ethnographic research (Marcus, 1995) conducted in the Netherlands and Slovakia in the context of an international research project on transnational organization of senior care (https://careorg.eu). To trace how live-in care work is organized across Slovakia and the Netherlands, we approached live-in care as a transnational

arrangement in which migration decisions and recruitment processes largely originate in Slovakia, while working conditions are shaped through interactions with Dutch clients, agencies, and institutions within the context of the Dutch welfare state.

We mapped the regulatory framework governing live-in care in the Netherlands by analysing legislation and policy instruments related to long-term care and personal budgets. We also explored the Dutch live-in care sector through providers' websites and other publicly available materials. To examine the everyday organization of this welfare market, we conducted semi-structured interviews and observations with care workers, intermediaries, and institutional actors across both countries. Between June and September 2024, we carried out 18 interviews in Slovakia with 12 Slovak care workers and six intermediaries recruited through Facebook groups and snowball sampling. In these interviews, we focused on migration trajectories, work practices, temporal work arrangements, and the role of agencies in organising transnational care. Alongside interview data, we also analysed work-related and administrative documents shared by care workers, including contracts, schedules, and agency materials. These materials helped us better understand the bureaucratic and organizational dimensions of transnational live-in care. In the Netherlands, we conducted five interviews with representatives from three organizations providing live-in care, including one agency that specifically recruits and coordinates Slovak care workers. We also interviewed representatives of a sectoral association and a regional care office (*Zorgkantoor*), as well as a Slovak agency manager based in the Netherlands.

This article is based on a collaboration between Czech and Dutch researchers. Siënna Hernandez conducted most of the interviews in the Netherlands, Kristína Bartošová conducted most of the interviews in Slovakia, and Franca van Hooren was primarily responsible for the policy analysis. Some interviews in the Netherlands were conducted jointly. They were conducted in Slovak, English, German, and Dutch, depending on the preferences of the interviewees. Where possible, we audio-recorded and transcribed interviews and complemented them with detailed field notes. The transnational composition of the research team played a central role throughout the research process, particularly in connecting ethnographic insights from Slovakia with institutional and policy perspectives from the Netherlands.

## 4. Mapping Dutch Policy Instruments

This section presents the results of our policy analysis and maps Dutch welfare market policy instruments in relation to live-in care work. Distinguishing between instruments of financing, regulation, information, and enforcement, we show that generous funding and tight regulations coincide with limited information and scattered enforcement authority.

### *4.1. Financing*

The Netherlands has a long history of relatively generous state funding of long-term care (Da Roit, 2018). Most funding is used to organize in-kind care services (including home care and residential care). People with permanent and intensive care needs are covered by the Long-Term Care Act, which provides either in-kind care or cash-for-care benefits. Care offices (*Zorgkantoren*) decide in consultation with the client whether care is provided in-kind or through a cash-for-care benefit (*PGB*/personal budget). The personal budget is managed by an administrative body (*Sociale Verzekeringsbank*/social insurance bank) and, notably different from other

states, it is not paid out to care recipients, but directly to the providers of care, i.e., either a care worker or a care providing agency.

The Dutch cash-for-care benefit for people with permanent and severe care needs is highly generous. It is paid at different levels, varying from EUR 4046 to EUR 8207 per month (in 2025), with the most frequently granted amount being EUR 5489/month. For comparison: Italy provides an unconditional flat-rate benefit of around EUR 550/month. Cash benefits under the German long-term care insurance range from approximately EUR 350 to EUR 1000 (Bundesministerium für Gesundheit, n.d.), and in Austria most recipients who need permanent care receive around EUR 1,175/month (Bundesministerium für Arbeit, n.d.). Despite its generosity, only approximately 8% of recipients of permanent and intensive long-term care in the Netherlands receive a cash benefit (the other 92% receive in-kind care; Ministerie van Volksgezondheid, 2025a). This is probably the result of the existence of good in-kind alternatives and the stringent regulations attached to the personal budget, to which we turn now.

### *4.2. Regulation*

The Dutch personal budget comes with very strict regulations on how it can be spent. These rules, which are largely driven by concerns about fraud and misuse of welfare subsidies, have been tightened repeatedly in recent years (Böcker et al., 2021; Da Roit & Van Bochove, 2017). To provide care financed through a personal budget, care workers must have a formal contract which is approved by a regional care authority. In addition, since 2022, a new Care Providers Accreditation Act (WTZA) stipulates that all care providers (including those who are self-employed or directly employed by families) must be formally registered as a care provider (Ministerie van Volksgezondheid, 2025b). Registration is conditional upon quality control systems, client councils, and compliance procedures. There is also a licensing requirement for care providers with more than 10 care workers, which, however, does not apply to subcontractors or self-employed providers.

Meanwhile, the Netherlands does not have any specific regulations for live-in care work, nor does the collective labour agreement for the care sector cover live-in care. Care workers who work for more than three days a week for one household or employer fall under regular Dutch labour law standards (exceptions apply only to those who are employed by a household for less than three days a week; see Van Hooren, 2018). Labour standards include a minimum wage (14 EUR per hour in 2025), a maximum average work week of 48 hours, and regular work-free periods (at least 11 consecutive rest hours per 24 hours and 36 consecutive hours every seven days). Regulations for being on call (for example, during the night) stipulate that this is counted as working time if the (care) worker must remain on location (Burri et al., 2018). Moreover, a worker can be on call for no more than 14 nights per month.

While these pay and working time regulations do not apply in case of "genuine" self-employment (characterised by short-term assignments for multiple employers and autonomy to decide on working times and execution), bogus self-employment is suspected when the client (*opdrachtgever*) decides on working time and when pay is set at a regular rate per hour or day worked (Rijksoverheid, 2026a). Where bogus self-employment is established, general labour regulations apply. This also applies to self-employed workers who are posted from another EU country.

### 4.3. Information and Enforcement

While detailed statistics exist on care workers' activities in regular (live-out) home care and institutional care (CBS Statline, n.d.), there is no register nor survey data on live-in care work. There is data on the frequency of use of personal budgets, but no record is kept of who uses this budget to purchase live-in migrant care work, nor are there registers for providers of live-in care.

Meanwhile, a range of regulatory and enforcement agencies have responsibilities related to different aspects of personal budgets and care arrangements, yet none of them is directly concerned with live-in care work. Regional care offices check contracts between clients and care providers; the social insurance authority pays care providers; the health care inspectorate (*Inspectie Gezondheidszorg en Jeugd*) enforces quality standards; the labour inspectorate (the Netherlands Labour Authority) controls compliance with labour standards; and the tax authority fights bogus self-employment. In Section 6, we discuss how the lack of information and the scattered enforcement agencies limit Dutch state control over the live-in care market.

## 5. Dynamics of the Dutch Live-In Care Market

This section describes the results of our interviews and observations of the transnational dynamics of live-in care work in Slovakia and the Netherlands. We show that, as in other European countries (Aulenbacher et al., 2021, p. 12), the employment of live-in care workers operates through layered brokerage chains involving Slovak agencies and Dutch partners. We examine how these actors navigate Dutch regulations and show how Slovak care workers, Slovak agencies, and Dutch agencies jointly produce precarity despite stringent regulations.

### 5.1. Precarity Experienced by Slovak Live-In Care Workers in the Netherlands

Slovak care workers primarily enter the Dutch live-in care market because it offers higher earnings compared to Slovakia, a pattern widely observed among Central and Eastern European caregivers across Western Europe (Bahna & Sekulová, 2018; Bruquetas-Callejo, 2019). Many interviewed Slovak carers also emphasised independence and flexibility. Most are formally self-employed, contracted through Slovak intermediaries and posted to the Netherlands. They typically work rotational schedules of about six weeks in the Netherlands followed by a similar rest period in Slovakia, a pattern common in European live-in care systems (Leiblfinger et al., 2021).

Despite being formally self-employed, many interviewees report signing contracts that, in our view, resemble employment contracts, including agreements on a maximum of eight hours of work per day or a minimum of sixteen hours of weekly leisure time. Meanwhile, interviews reveal a clear mismatch between contractual representation and lived experience. In practice, working times are structured around the needs of the care recipient and are often longer or more unpredictable than is suggested in written contracts. Caregivers describe being woken repeatedly during the night and feeling unable to refuse requests for assistance, as care obligations extend beyond what would normally be considered protected sleep time. Mia (26) explains:

> He woke me up twice at night. I had to come…you can't just close the door…because you never know what will happen….When the call comes, you must come right away. You can't separate it or complain that you are tired.

Rozália (39) recalls never receiving a contract that clearly defined working hours or leave. As a result, she was never certain whether she was entitled to time off and had to negotiate this informally with the client's family. Such informal negotiation is typical in migrant live-in care work, where employment relations depend heavily on interpersonal arrangements (Shutes & Chiatti, 2012, p. 398). The issue concerns not only long working hours but also the fragmentation of "free time" into frequently interrupted breaks. Within this context, caregivers often describe "freedom" in spatial rather than contractual terms: Being free means physically leaving the house. This reflects a practical workaround to the absence of enforceable rest-time boundaries. Lujza (28) frames leaving the household as a temporary escape from a totalising work environment, explaining that she goes out "just to get out of the house, because it's all just work," a strategy documented among migrant domestic workers seeking limited autonomy outside the household (Fedyuk, 2020, p. 160). These experiences illustrate a key feature of live-in care: blurred boundaries between working time, on-call time, and personal time within private households (Ezzeddine & Matiaško, 2026, p. 7).

Rather than guaranteeing clear limits on working hours or rest periods, contracts often further constrain care workers' freedom. Vera, a self-employed worker contracted by a Slovak agency, showed us her contract, which framed care as a "business activity" and included financial penalties (for example, for not starting work [EUR 300], for leaving before a replacement was found [EUR 300], or for working directly with a client within twelve months [EUR 3,000]). Even mistreatment did not necessarily void these penalties, suggesting that the contract functioned more for disciplining exit than for protecting care providers, a mechanism also observed in other European live-in care markets (Aulenbacher et al., 2021, p. 14).

Remuneration of care workers is typically based on a daily rate and depends on the caregiver's qualifications as well as the severity of the care recipient's needs. In our fieldwork, reported pay ranged from EUR 60 to EUR 90 per day. In addition, some care workers receive a weekly allowance of up to EUR 70 for food. During a six-week work period, caregivers earn between EUR 2,500 and EUR 3,800. Since these six weeks of work are usually followed by six weeks without paid work, the effective monthly income ranges between approximately EUR 840 and EUR 1,260.

The work practices described by the Slovak care workers we interviewed suggest that their contractual engagement is a form of bogus self-employment, where workers formally operate as independent contractors but function as dependent employees (Leiblfinger et al., 2021, p. 497; Sagmeister, 2024). Meanwhile, the working conditions reported by the Slovak care workers do not comply with Dutch labour standards for dependent employees. While interviewees report working more than full time, the reported pay is much lower than Dutch minimum wage standards, EUR 112 for an 8-hour workday (in 2025). The described practices of being on call nearly all the time are not allowed according to Dutch working time regulations, which stipulate a minimum rest period of 11 hours per day and prescribe that a worker can only be on call for two weeks out of every four weeks.

However, the administrative arrangement of self-employment and posted work makes it difficult for Slovak care workers to identify who is accountable for their working conditions. This means they are dependent on

the enforcement of minimum standards by Dutch authorities, which, as we will show in more detail below, is also limited. Meanwhile, care workers' limited Dutch language skills further undermine their ability to negotiate working conditions, establish boundaries, and understand their rights. In the weakly formalised sector of home care, limited language competencies place migrant care workers in more vulnerable and dependent positions (Bahna, 2020; Fedyuk, 2020, p. 160; Gábriel, 2020). Agencies often do not provide systematic language training, meaning workers are dependent on self-study (Renáta, 34, coordinator).

### *5.2. Slovak Intermediaries Deliberately Constructing Precarious Work*

Slovak brokering agencies operating in the Netherlands are typically small to medium-sized. They are privately owned and specialize in live-in care. They have a small administrative team, personalised coordination practices, and informal transnational networks rather than large corporate infrastructures. Agencies operate transnationally, often maintaining their main administrative base in Slovakia while collaborating closely with Dutch partner agencies that represent clients and families in the Netherlands. Slovak agencies thus play a key role in structuring employment relations and working conditions (Aulenbacher et al., 2021, p. 13) and play a central role in recruiting and coordinating caregivers for Dutch households. In Irena's (45, agency owner) description, "the Slovak agency recruits and employs the care workers, while Dutch agencies find the clients."

It is worth mentioning that several agencies encountered during our fieldwork were founded or managed by former care workers. This is noteworthy because live-in care work is often associated with limited opportunities for career development. Yet some care workers progress to management positions:

> I worked with tulips when I first arrived here [in the Netherlands]….At that time, my friend was working as a care worker for a Slovak agency in the Netherlands. So she pulled me in as a care worker for the company. And I gradually worked my way up from care worker to coordinator, from coordinator to manager….I started doing care work when I was 21 years old. (Milada, 45, manager)

For other care workers, their experiences provided them with the necessary expertise and transnational networks to start their own agency. As one Slovak agency owner explained, her previous care work for another agency provided her with contacts and practical know-how that could later be mobilised to establish her own agency (Irena, 45, Slovak agency owner).

The interviews with the agencies reveal that the reliance on self-employment arrangements is explicitly seen as flexible and administratively convenient. It is presented as an advantage that in this type of employment relationship, working conditions are difficult to contest. One coordinator summarised the contractual implications bluntly: "As self-employed workers, their hours aren't limited" (Hana, 48). The same coordinator acknowledges: "You are guaranteed 16 hours of free time per week, but those hours…you were basically on standby."

Meanwhile, many agency owners point to the risks involved in extended payment chains linking Dutch clients, cash-for-care allowances, Dutch agencies, and Slovak intermediaries. Irena (45) emphasises that this structure creates financial vulnerabilities for agencies as well as caregivers:

> There's always a risk involved, especially because I depend on payments from Dutch [agencies]….I've had the experience where a Dutch [agency] didn't pay, and unfortunately, I couldn't pay the care worker either….So, as a Slovak agency, we bear all the risk. The Dutch agencies are private businesses too; it's not state-run.

Such fragmented financial arrangements are typical of transnational care labour markets and expose migrant caregivers to delayed or missing remuneration (Leiblfinger et al., 2021, p. 498).

Slovak agencies are responsible for the recruitment of care workers. Their recruitment practices illustrate tensions between professional standards and labour shortages. As coordinator Renáta (34) explains, agencies "cannot afford qualified caregivers because they are too expensive." By choosing care workers with fewer formal qualifications, agencies can tailor the level and cost of care to their budget. In practice, economic pressures shape recruitment decisions. Coordinators recall moments when agencies could not afford to be selective, accepting "almost anyone" simply to fill gaps. According to Renáta, "in 90% of cases, we were just grateful that we had someone at all," while another coordinator remembers the misery of having to choose "between bad and worse." Growing demand and labour shortages thus encourage agencies to prioritise availability over qualifications.

Consequently, although agencies nominally mention requirements such as caregiving certificates, references, and language skills, these standards are frequently enforced more formally than substantively. Božena (40), an HR manager, describes the official requirement of an EU-accredited caregiving certificate:

> They need to have, for example, the Red Cross or an educational academy requires a certain number of hours of training, I think 280, or she must have medical school training, medical education…as long as she has the basics.

Yet care workers' accounts suggest that such formal requirements are not always met in practice.

### *5.3. Dutch Care Provider Agencies Formalising Precarious Arrangements*

As with their Slovak counterparts, Dutch agencies tend to be small or medium-sized. While live-in care remains relatively rare in the Netherlands, the online visibility of these agencies has increased in recent years. Several providers have recently joined a sectoral association that represents providers of (live-in) home care services. The agencies position themselves as a "solution" to perceived shortcomings of the Dutch long-term care system. Across interviews, migrant live-in care is consistently contrasted with what respondents describe as the fragmentation of regular home-care services. While Slovak agencies are sometimes founded by former live-in caregivers, Dutch providers sometimes cite personal experiences of arranging care for family members within the Dutch healthcare system as a motivation for establishing their organization. For example, one of the founders had a family member for whom they had previously set up a live-in care arrangement.

Dutch agencies that organise live-in care prefer not to be called agencies but rather "care providers" (*zorgaanbieders*). In the past, these organizations acted merely as brokers, bringing Dutch care recipients and migrant care workers or foreign agencies together. In recent years, they have transitioned into private

enterprises (Fudge & Hobden, 2018) that directly sell live-in care services to clients. This transition is closely related to changing Dutch policy instruments as we will explain hereafter.

The Dutch care-providing organizations present themselves as operating in, but also against, a dense web of Dutch regulations, protocols and institutional expectations. One care provider repeatedly stressed that "the Dutch healthcare system, or systems, are not geared towards this," referring to cross-border arrangements. From their perspective, rules that were designed with domestically rooted institutions in mind are poorly suited to organizations that operate transnationally. This becomes especially tangible in the requirements tied to the WTZA, which entered into force in 2022. To meet the WTZA notification requirement, every care provider must, among other things, provide a Chamber of Commerce number and demonstrate that they have a client record system, a quality management system with written protocols, and a client council. One interviewee underscores how difficult this is for agencies or individual care workers whose operational centre is not in the Netherlands, asking us to imagine "organizing a client council from your office in Lisbon or somewhere in Poland" (Peter, manager at a Dutch care provider organization).

Against this backdrop, providers have adapted by strategically reshaping their formal role in the system. Where in the earlier constellation the Dutch agency acted as an intermediary, and it was the international care provider (e.g., a Slovak agency) who had a contract with the client, since the tightened quality control regulations of 2022, Dutch agencies have become the formal providers of care. Meanwhile, in reality, many arrangements, such as recruitment through partner agencies abroad, remain unchanged. This move can be seen as a way of aligning with the regulatory expectations that structure the Dutch welfare market. A Dutch entity now sits at the interface with the state, formally complying with all regulatory requirements. This shift can also be understood as a form of corporatization (Farris & Marchetti, 2017). The organization takes on the shape and language of an institutional care provider, with quality systems, protocols and formal client councils, not only to meet legal standards, but also to gain faster access to public money and to be recognised as a legitimate actor in the field.

Formal compliance does not eliminate the grey zones that characterise migrant live-in care. While providers claim to pay according to the collective labour agreement and to respect a 40-hour work week (see also Da Roit & Van Bochove, 2017), the accounts of care workers being required to be constantly available put that into question. Here we need to acknowledge that agencies differ (Leiber et al., 2019). Some Dutch agencies may prioritise and have more success in maintaining minimum labour standards than others. However, because the employment or contractual relationship with care workers is outsourced to partner agencies abroad, who in turn—at least in our Slovak case study—engage self-employed care workers, the responsibility for and control over working conditions is shifted away from the Dutch providers. Consequently, the transition from intermediary to formal care provider is both a tactic to navigate Dutch bureaucracy and a mechanism that keeps much of the transnational and precarious character of live-in care hidden "behind the scenes," even as the care providing organizations present themselves as fully aligned with Dutch rules and institutions.

## 6. Enforcement Gaps and How Precarity Remains Invisible for Dutch Regulatory Authorities

In this section, we zoom in on how instruments of information and enforcement affect the dynamics of the Dutch live-in care market. As we already noted in Section 4, Dutch authorities record little information on

live-in care work and regulatory responsibility is dispersed and divided between different institutions responsible for eligibility, financing, care quality, and working conditions. This institutional distribution shapes what aspects of live-in care become visible to regulators, and which remain outside their scope, as is graphically depicted in Figure 1 and further explained below.

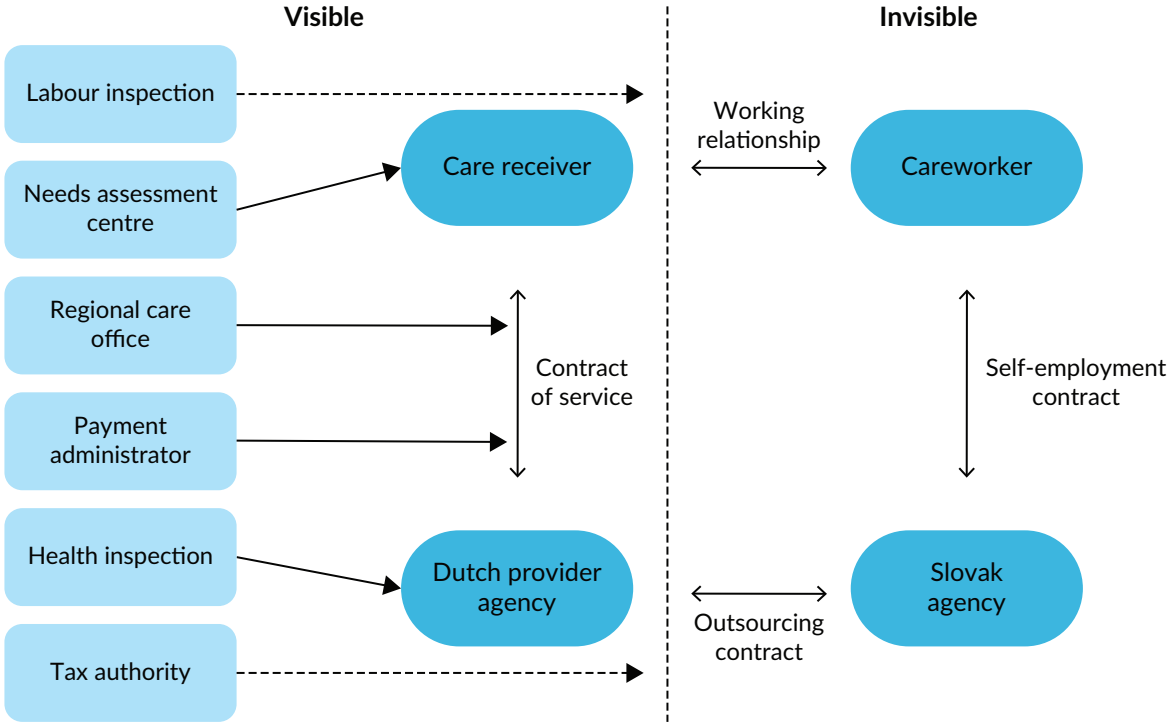



**Figure 1.** What is visible and invisible for Dutch regulatory authorities.

The needs assessment centre determines eligibility for publicly funded long-term care and the level of care required, but not the form in which this is provided. Once eligibility is established, regional care offices evaluate whether care recipients are eligible for personal budget funding. In the case of live-in care, these offices function as important gatekeepers because they approve the contracts through which care is organised. However, an interview with a representative from one care office suggests that this form of care is not systematically monitored. Service contracts (*zorgovereenkomst*) categorize services in ways that do not distinguish live-in care from other forms of home care, which limits the institutional visibility of the practice.

Yet another institution (the social insurance bank) acts as payment administrator and pays out personal budget funds to care providers, in this case the Dutch care-providing organizations. According to one of our interviewees, in the past, the payment administrator treated international providers as inherently risky. Dutch authorities "see something foreign and immediately: Hey! All the red flags" (Peter, manager at a Dutch care provider organization). Even after passing initial checks, foreign providers would remain subject to repeated scrutiny, as though their foreignness alone constituted grounds for continued suspicion. Only after the formal care provider became a Dutch organization—which still subcontracted services to the same international providers as before—payments were administered directly and without much critical scrutiny. This development of channelling personal budgets through Dutch care-providing organizations has important implications, as it has made intermediaries, such as Slovak employment agencies, and the care workers themselves *less* visible within the administrative structure, as is visualized in Figure 1.

Another important enforcement authority is the Dutch Health and Youth Care Inspectorate, which supervises whether formally registered care providers comply with professional standards and safety requirements. We retrieved a recent inspection report of a live-in care provider, which illustrates how this regulatory framework encounters the organizational model typical of the sector (the report is not cited here to preserve the anonymity of the organization, but it was retrieved from the Health and Youth Care Inspectorate, 2026). The inspection report shows that the Inspectorate is aware of the organizational model of the provider, noting that it works with a foreign subcontractor and self-employed foreign carers who live-in and work for six consecutive weeks in the Netherlands. Yet the Inspectorate does not engage with this revelatory information in any way. It does not signal that this constellation likely involves bogus self-employment according to Dutch law, nor does it address the working conditions of these care workers. Instead, the report focuses on qualifications obtained abroad that had not been formally recognised within the Dutch professional framework as well as missing criminal background checks. Rather than problematising the staffing model, the inspectorate addresses these issues through its standard quality-improvement approach. The Dutch provider is required to ensure that caregivers possess qualifications recognised in the Netherlands and obtain the necessary background checks. The report then expresses confidence in the provider's capacity to implement improvements. This example shows how fragmentation of control leads to a situation where, even when potentially problematic cross-border labour arrangements become partly visible, this information is not shared with the authority responsible for working conditions.

Meanwhile, the Dutch labour inspectorate, the authority that enforces labour standards, is hampered by limited knowledge of the live-in care market and the absence of an easily controllable workplace. In recent years, it has encountered several individual cases of severe transgression of labour standards in live-in care, much in line with practices described by care workers in our fieldwork (see, for example, Nederlandse Arbeidsinspectie, 2022, p. 25), yet the labour inspectorate only acts after a worker or an NGO has signalled exploitative practices (Van Wanroij, 2025a). That this is unlikely to resolve systematic problems can be inferred from our fieldwork, which showed that Slovak care workers do not know who is responsible for their working conditions, let alone possess the legal and language capabilities to involve Dutch authorities.

Finally, the invisibility of Slovak self-employed care workers is reinforced by the fact that their economic activities remain formally rooted in Slovakia. They are paid by Slovak agencies, pay taxes in Slovakia, and sign a European A1 form—this is frequently mentioned by our interviewees—which certifies that they fall under Slovak social security regulations. Consequently, their work never becomes visible to the Dutch tax or social security authorities. This is important, because it is exactly the Dutch tax authority that has recently tightened its enforcement of self-employment regulations to combat bogus self-employment (Rijksoverheid, 2024), i.e., situations where self-employed (care) workers do not retain control over how and when they work, or do not have multiple clients. Consequently, while Dutch care-providing organizations and self-employed care workers registered in the Netherlands risk prosecution when they engage in practices of bogus self-employment, this practice has so far gone unpunished when outsourced to foreign subcontractors.

Taken together, these arrangements reveal systematic limits to institutional oversight in the highly regulated Dutch care market. Responsibilities are fragmented across multiple organizations and the working conditions of live-in care workers often remain administratively invisible. Funding institutions oversee care budgets and contracts but have no institutional responsibility for labour relations. Meanwhile, practices of bogus

self-employment and labour exploitation remain mostly invisible to the organizations responsible for enforcement, such as the Labour Inspectorate and the Tax Authority.

## 7. Conclusion

It has been suggested that the highly regulated nature of the Dutch cash-for-care benefit limits regulatory grey zones (Böcker et al., 2021) and improves working conditions (Da Roit & Van Bochove, 2017) in comparison with other less-regulated cash-for-care schemes (Da Roit & Le Bihan, 2010; Van Hooren, 2012). Our findings indicate that this is not the case: Agencies actively produce semi-formal "in-between spaces" through legal and organizational workarounds. In a heavily regulated market, live-in care is organised through subcontracting chains that obscure highly flexible employment arrangements, most commonly self-employment. When regulations are tightened, information about employment relations is actually lost, and effective oversight becomes more difficult. Subcontracting chains and self-employment allow agencies in the Netherlands and Slovakia to avoid obligations related to working time, guaranteed rest, and paid leave (Aulenbacher et al., 2021).

Vulnerability is therefore not an unintended side effect but an integral element of the model, making the state complicit (Lutz & Palenga-Möllenbeck, 2010). While Dutch care-providing agencies present themselves as facilitators of formal care, both Dutch and Slovak agencies profit from operating within weakly enforced regulatory spaces through subcontracting and self-employment arrangements that shift risks and responsibilities onto care workers. This produces a persistent asymmetry of power between agencies and caregivers and reflects broader processes of marketization and commodification of care that reproduce structural inequalities and precarization within private households (Uhde, 2016, p. 395; Uhde & Ezzeddine, 2020, p. 27). As a result, care and labour standards are continuously negotiated in practice and depend on the specific situation (Böcker et al., 2021; Steiner et al., 2020). Limited language proficiency further weakens caregivers' bargaining power and reproduces gendered, ethnic, class-based, and power asymmetries within live-in care arrangements (Bahna, 2020; Fedyuk, 2020).

These vulnerabilities do not stem from an absence of regulation as such, but rather from regulatory gaps, workaround practices, and the transnational organization of care within private households. The case thus reveals a paradox of welfare governance: The design of funding, regulation, information, and enforcement systems simultaneously structures what becomes governable and what remains unseen, allowing formal compliance to coexist with persistent blind spots. More generous public subsidies or tightened regulations do not necessarily improve working conditions.

This Dutch–Slovak case study, premised on generous Dutch cash-for-care benefits, suggests that 24-hour live-in care can hardly be organised in a financially sustainable way while also adhering to minimum labour standards. According to European standards, also applicable in the Netherlands, all on-call time where care workers are not allowed to leave the house should be counted and paid as working time (Rijksoverheid, 2026b; Van Wanroij, 2025b). Consequently, 24-hour care paid at Dutch minimum wage would cost some EUR 10,000 per month for labour costs only (hence excluding intermediary costs, taxation, or social security benefits), which already amounts to nearly twice the level of the Dutch cash-for-care benefit.

Meanwhile, given that live-in care work is a reality that is not likely to disappear soon, our case study echoes some concrete points of attention for protecting working conditions in welfare markets, which have also been brought forward in other research. First, live-in care workers should be given more systematic time off, also during the night, and regulation needs to limit the possibility of using self-employment arrangements in live-in care (Österle & Bauer, 2016; Sagmeister, 2024; Schmidt et al., 2016). Second, authorities must gather information by requiring registration in the country where care is provided and creating administrative categories that specifically reflect live-in care work. Third, the authorities that control welfare markets must cooperate and make the enforcement of working conditions one of their priorities.

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## Conflict of Interests

In a future Horizon Europe "Rights4CareWork" research project, one of the authors (Franca van Hooren) will collaborate with the NGO Fairwork, which fights labour exploitation of migrant workers in—among other sectors—live-in care work in the Netherlands.

## Correction Statement

This article has been republished with minor corrections to fix spelling, grammar mistakes, and/or typos. These changes have no impact on the scientific content of the article as it was originally published.

## Data Availability

This article is based on fieldwork and interview data that are not disclosed for reasons of anonymity and privacy. All other sources are listed as references.

## LLMs Disclosure

UvA AI Chat was used for language editing of a few segments of the article.

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