Caring: The Shifting Value and Changing Performance of Care under Neoliberal Governing

Wiggers, Dewi

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Dewi Wiggers s2138611

Supervisor Mark Westmoreland

Second reader Sander Hölsgens

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Abstract

This thesis explores the manifestations of neoliberalism in governing practices and its impact on care and careworkers in the Dutch care system. Through a literature analysis, we explore the arrival of neoliberalism and how it established in Dutch politics. On the basis of a mixed methods approach, with special attention to visual methods. This research studies how neoliberal governing practices as a response to an ageing population, such as the implementation of market-competition and deregulation in order to achieve cost-efficiency, have fragmentized care practices on multiple levels. This fragmentation has led to a decay of the relational space that is essential to care as an inherently intimate practice. Consequently, careworkers have rang the emergency bell, declaring a “care infarct”.

[care; careworkers; deregulation; emotional capital; governmentality; market-reform; neoliberalism; neoliberal programmatic blindness; policy]

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Introduction

The sight of my mother falling asleep on the couch in her stark white uniform, name tag still on, has been ingrained in my memories. More often than not, we would be having our afternoon tea after school and work, and I would feel her head become heavy on my shoulder while her tea became cold. I would hear her snoring within the first ten minutes of our movie night on Saturday evenings. I considered it nothing but normal back in the day, but in more recent times, I started to reflect on these sights of exhaustion.

In our later conversations, she told me how her job as a careworker often felt like too much, both physically and emotionally. Not only the physical act of dragging people in and out of their beds, on and off their toilets, day in and day out, took its toll on her body, resulting in back problems and medical prolapses later on in her life. It also impacted her mentally and emotionally. The feeling of losing her patience with an uncooperative patient when twenty-eight others are waiting to be showered and the guilt afterwards; dealing with the aggression of demented elderly that have lost their sense of time and space, and take out their panic and frustration on those trying to help and protect them; or simply the sight of elderly in their last phase of life that have lost all autonomy.

My mother, Inge, started working as a careworker when she was seventeen and three months, at ‘De Lozerhof’, a psychogeriatric nursing home in The Hague, the Netherlands. She was younger than was officially allowed, but they condoned this on the terms of doing summer work first. Her education allowed her to both study and work simultaneously while residing internally on the top floor of the nursing home with other female colleagues. She will always remember the penetrant smell of piss when she first entered the department; the discomfort she had to put aside seeing and touching a naked human, in all their shapes and sizes, for the first time; and the apprehension towards the head nurses in the deeply hierarchal workspace. There were a lot of impressions to digest, and Inge and her colleagues had to buckle down. Although the work was tough, her most prominent memories come from the good times she had together with her colleagues. The sense of solidarity, “We’re doing this together”, and the fun they had along the way.

But the positives that outweighed the negatives in the beginning, seemed to decline as a turbulent career in the healthcare sector followed. After five years in ‘De Lozerhof’, Inge transferred to work at two elderly homes, where patients had lighter medical and mental conditions, elsewhere in the city for the next three years. Due to a “growth of lack of patience” and irregular schedules that did not match with her husband’s, she shifted towards a nine-to-five office job. Five years after the birth of her child – me, we moved to the east side of the country. As there was a great lack of staff in carework, she was happily received to re-enter carework after 12 years. Again, she worked at a nursing home for elderly, starting slightly insecure due to the large break in her care practices and the changes in the field. Care tasks were separated, new technologies implemented, administrative tasks increased, night, weekend- and holiday shifts had become obliged for everyone and a national lack of staff had

increased the work pressure. A few years in, Inge also completed her study as a yoga teacher, next to her job as a careworker. Now working as a yoga teacher two evenings a week, the inflexibility and insecurity surrounding the nightshifts, in combination with guilt towards her daughter for not being able to be present during certain festivities such as Christmas and school performances, she exchanged the full-time job for freelance substitute work. This way she had more control over her schedule to combine her private life with work, but it simultaneously created more financial insecurity, as the paycheck differed per month. The financial struggle continued as the 2007 global economic crisis hit the Netherlands as well. Moving back to the West due to personal circumstances and in desperate need of job security, Inge was willing to take any job that would provide financial security. She found a job at a nursing home in a closed department, under the condition of simultaneously studying to become a First Responsible Careworker. She finished her studies, but left as soon as she could find another job. She was shocked to see the decline in her work field. New ways of working due to austerity measures did not meet the standards of care she was trained to give. Mistakes were made in dispensing medicine; patients were left in their diapers full of shit, because toilet rounds were skipped to save time for the understaffed team; too many colleagues were on the edge of burn-out, causing high sick-leave rates. A series of incidents with patients, which Inge describes as “inhumane”, was the last straw for her.

> “I know I’m a sensitive person, which is also partially why I am good at this job, but this became too much. I could no longer tell my patients to shit in their diaper when they asked to be toileted. I could no longer ‘shower’ my patients without water to ‘save me time’. I could no longer bare the distress these things caused towards my patients or myself. I just couldn’t.”

The care she was expected to give after re-entering the care sector did no longer resonate with the care she wanted to give, or was trained to give. After trying one more elderly home, she left the care sector for the second time. Now going through a divorce and taking any job, she worked at a call centre for almost two years. Longing for more human contact in her job, she reached out to the field of elderly care again, but now determined to only take a job that would not exhaust her as it had done in the past. She re-entered the field as a domestic help for elderly. Only part-time, as full-time would be too heavy on her 50+ year-old body. Even though it was physically demanding and thus temporary, she re-found her love for carework: giving “aandacht”, conscious attention and interest, to elderly; seeing them for who they are and being able to mean something to them. She stayed within the same organization, who recognised she was extremely over-qualified for domestic help and, with clear negotiation of what she did and did not want, slowly offered her a spot at the daycare for early staged dementing elderly, where she now happily works for the past five years.

The problems my mother encountered in the Dutch healthcare sector, do not stand alone. News sources post articles about issues in the care sector on a weekly basis. A lack of staff, high sick leave

rates, high work pressure, an increase in administrative tasks and almost half of the new graduates leave the sector within two years. Care manifests call out an "institutionalised distrust"[1] towards care professionals woven into the current care system and opt for careworkers to have a say in care policies[2]. Careworkers themselves have declared a "care infarct"[3], where careworkers and medical professionals can no longer deliver the care they are expected to give.

There is one big issue the care sector has been dealing with and will continue to have to deal with in the future: an aging population. Not only the percentage of 65+ers has been and still is increasing while the percentage working population is decreasing, there are also more people living longer with chronical, or a multitude of chronical deceases due to technological developments. These two major factors have contributed to a massive increase in health care expenses over the past decades and will continue in the future. With respects to 2018, healthcare costs will have doubled by 2040[4]. The Dutch government has responded to this issue with a long history of austerity measures. Following the neoliberal thought that gained popularity since the 1980s, and implementing privatization, market-competition, deregulation and a firm focus on cost-efficiency, the Dutch care sector has had to endure decades of austerity measures and reformations.

In this thesis, I will explore how neoliberal governing has impacted the value and performance of care, by taking the direct work floor experience of careworkers as a lead. Starting off with a literature review on how neoliberalism entered Dutch politics we explore how neoliberalism has been manifested in Dutch care policies and other relating governmental practices. Through the experiences of how careworkers have seen their care practices change over time, gained through a mixed method approach with special attention to visual methods, we explore the effects of neoliberal governing on the organization of the care system. We see how the fragmentation of care as a consequence of the cost-efficiency leads to a shift in value, where the financial value of care overshadows the societal value. By zooming in on the daily experiences of careworkers I show carework as an inherently intimate practice that, under neoliberal policies and regulations, cannot be performed in the way careworkers are expected to, leaving them stressed and frustrated up until the point of declaring the Dutch care sector to be in a care crisis.

[1] https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/borst-zorgcultuur-is-gebaseerd-op-wantrouwen Manifest Scherp op Ouderenzorg – Hugo Borst en Carin Gaemers (consulted on 18-07-2023)
[2] https://www.nurseminded.nl/wp-content/uploads/2021/11/Nurse-Minded_definitief_copyright-1.pdf (consulted on 22-03-23)
[3] https://www.medischcontact.nl/opinie/blogs-columns/blog/zorginfarct-tijd-om-te-dotteren (consulted on 18-07-23)
[4] https://www.vtv2018.nl/zorguitgaven (consulted on 18-07-23)

A Film and Thesis Synthesis

Attached to this thesis is a film that picks up on the story in the introduction of this thesis, my mother. During this research, my mother and her colleagues, the characters in the film, served as an in-depth case to understand the changes and its consequences within Dutch care film. Next to providing in-depth qualitative data for this written thesis, my mother's story also translated into a film. It serves as a *portrait* through which I hope to convey her "impressions as evidence and [let the viewer] understand what is happening around [my mother] through their emotional connection to [her]" (Lawrence 2020: 141). We see her as both a paid professional careworker in elderly care, as well as an unpaid familial caregiver to her mother, who is diagnosed with Alzheimer's. The film shows how my mother's everyday life intertwines with the deregulation of care and the increasing deployment of familial care as a result of neoliberal governing in the Dutch care sector. As the film focusses on the first-hand experiences of careworkers and give insight in what it is like to perform such an intimate yet professional practice, this written thesis clarifies the sociopolitical economic mechanisms behind it.

Filming and Editing as a Method

The film does not only contribute to this thesis as a visual output, but also as a method of analysis. In the process of film-making, ethnographers "translate our own experience and that of our collaborators into a related experience for the audience" (Lawrence 2020: 12). This is an "interpretative process" and requires analysis of visual material that helped me in understanding care as an intimate practice. As the film does not seek to resemble the reality of careworkers, as that is not only "impossible but also unwanted", as Suhr & Willerslev (2013) explain in their book Transcultural Montage, it does aim to grasp and create an understanding of the reality of careworkers. And this editing process of visual analysis contributed to this understanding for the written thesis also.

Theoretical Foundation

What is care? Part of this research is not to answer this question, but to actively push this question to the foreground, rather than taking it for granted. What do we define as care? What do we consider to be good quality care? Who is responsible for its access and delivery? And what do we as a society want care to look like? The word care is used in various contexts with various meanings. Therefore, it is important to establish a basic framework to work from. In this research, care will be demarcated as paid, professional care. This research undertakes the perspective of careworkers that deliver direct care, meaning that they are in direct, physical and emotional contact with patients, clients, residents and visitors that receive paid, professional care. The focus of this research, lies predominantly in the field of long-term care that mainly concerns elderly, chronically ill and mentally or physically disabled people. However, most participants also have work experience beyond fields, such as hospitals, youth care and maternity care. The experiences in these fields have not been ignored, but taken into account in relation to their experiences in long-term care.

Care as an Intimate Practice

Beyond the practical considerations of care, we also have to dive into our understanding of care in anthropological terms. Starting with the most basic understanding, care refers to "the ways in which communities and individuals attend to and provide for each other" (Corwin 2020: 638). But here too, we bump into care as a "shifting and unstable concept", depending on its use and context (Buch 2015: 279). In this research, I approach care as an inherently *intimate practice*. Care receivers, like the elderly, require help with activities and routines they used to do by themselves. They become dependent on another person for their most basic needs, some of which are usually done in solitude, like toileting, showering and getting dressed. Care is therefore more than just the performance of routinized tasks. Care practices touch upon a patient's personal and intimate space. Care does not only enter the intimate space of the patient but also that of the careworker. The interaction of the careworker and their patient takes place in a space where the "private and public are fundamentally blurred" (Clare 2011: 11). The careworker is paid and bound to a set of regulations and routines, yet simultaneously enters a personal realm that requires emotional involvement and attunement to their patient. Care is very much delivered by creating and maintaining a *relational space* (Thompson et al 2021: 4). This is done through the expertise of the health care professional and consists of two components. First, it concerns a certain *being* that refers to qualities innate to the careworker that provide the "foundation" from which they work (Thompson et al. 2021: 5). These are "trained and embodied capacities and tendencies" that "guide their thoughts, feelings and actions". This encompasses qualities of being emphatic, understanding, accepting, genuine and kind. The second component is *knowing and doing*. This does not simply refer to the execution of tasks. It is about knowing what to do in a specific situation and tuning in to the client's needs and preferences. Care is

not a one-size-fits-all activity. Good quality care is done with intention and attention (Thompson et al. 2021: 5). Thompson et al (2021) stress the importance of "*responding to"* as a "significant action". It consists of the "ability to reassure, normalize, explain, downplay, use humour and coaching when providing care" (Thompson et al. 2021: 6). It is this practice that eases the emotional impact and possible stress for the care recipient that comes with the provision of intimate care. Care workers do not only anticipate the needs of the care receivers however, they also need to take their own needs into account. Care workers are aware that they themselves are the "instrument" of care (Thompson et al. 2021: 6). They recognize their emotional involvement in the job. Emotion is fundamental to care practices as it influences how care is given and received. I consider this to be a form of capital. *Emotional capital* then refers to the being, knowing and doing of emotion by careworkers. I use emotional capital rather than emotional labour, which is often used in these contexts. Emotional capital refers to a "relational skill" to deal both with their own emotions as well as the emotions of their patients they encounter during work (Clare 2011: 21). It is essential to caregiving jobs and helps careworkers in their work performance. I see *emotional labour* as a component of emotional capital. In its original use, emotional labour refers to effort needed to hide personal, private feelings and instead perform a different, desirable emotion into public display. Because of a mismatch between the private feeling and the public emotion, it is considered a form of labour that is associated with alienation (Hochschild 1983: 19). In care giving practices however, it is often not a mere "display of emotions", but are often coming from genuine bonds created between careworker and patient. Although emotional involvement in care practices can certainly impact the careworker negatively, like alienation as a result of emotional labour, it is the exact same emotional involvement that adds value and satisfaction to the job. The consequences of emotional capital as a part of care giving practices "are largely dependent on the context of emotion management" and can both drain and empower careworkers (Clare 2011: 10). I therefore introduce *emotional empowerment* as the counter component of emotional labour. They are the two sides of the same coin.

Emotional capital, executed through a *relational space*, is a deeper layer that runs through the *being*, *knowing and doing* of care practices. Careworkers use specific strategies to deal with their own needs during their care practices, such as being present in the moment, not taking a patient's response personally, and taking a moment to breathe and re-centre themselves (Thompson et al. 2021: 6). When entering the intimate and relational space that is essential to caregiving practices, caregivers need to tune in with their patients and themselves and anticipate to their needs. They need to actively engage, get to know their patients and anticipate their needs and preferences on a day-to-day, or even moment-to-moment basis. Care thus does not only comprehend *what* kind of care is delivered, but also about *the way* in which care is given (Thompson et al. 2021: 7). Even though care is practised through regulations and routinizations, it is simultaneously a wholistic practice in which emotional capital plays an essential role in a careworker's professional expertise.

Neoliberalism: More than an Ideology

The deployment of emotional capital is crucial to care practices. In the above I have stated that in order to perform this emotional capital through the profession of being, knowing and doing, the careworker creates a relational space in which this practice can exist. The creation of this relational space however, is not solely dependent on the direct relationship between care giver and care receiver, but rather affected by an "interplay" of different levels of care provision (Thompson et al. 2021: 8). The relational space also needs to be facilitated by the way care is shaped and organized by institutional regulations and national policies and laws. If we want to understand those care policies and regulations and their effects, we have to "examine the ideas behind them" in order to help us understand "what the policies do, what social effects they have, and how they are connected with larger social[, political and economic] processes" (Kesjavjee 2014: 12).

The problems currently encountered in the Dutch care sector, dealing with an aging population and consequently rising expenses, have been met with a series of austerity measures, privatization, deregulation and a market-reform. It is clear that the Dutch government has been following the trend of neoliberalism, of which Reagan and Thatcher have been figureheads since the 1980s. Neoliberalism has heavily, although not explicitly as we will see later, influenced Dutch governance over the past four decades. First I will establish how I use neoliberalism in this thesis.

Neoliberalism refers to a political economic ideology with a belief that market-competition is the most effective and efficient model to regulate the social structures in society, known for practices like privatization, decentralization, deregulation and market-reforms (Ganti 2014: 91). In contrast to classic liberalism which advocates the reduction of government interference, neoliberalism functions through an interplay between market-competition and the government, viewing the government as the facilitator and regulator of the market. Neoliberalism thus does not seek a "retreat of the state", but rather a "transformation of state action", accumulating to the rules of competition and subject to cost-efficiency "similar to those experienced by private enterprises" (Cahill 2015: 205).

Schrecker (2016) addresses the four faces of neoliberalism. "[Neoliberalism is] simultaneously an ideology, a set of policies and programmes, a set of distinctive institutional forms, and a complex of normative conceptions of agency and responsibility that are rooted in the ideology and embodied in the policies, programmes and institutional forms" (Schrecker 2016: 477). Neoliberalism functions both on an ideological level, in values and ideas, but also manifests in governmental practices.

To analyse how neoliberalism manifests in governmental practices, I draw upon the concept of *governmentality* as a basis. The Foucauldian term can be understood as an "art of governing" that influences and changes the way individuals and institutions think and behave, as a way of executing power (Foucault 1997: 82). Rather than a form of direct power, like sovereignty that has almost always been paired with resistance, governmentality shows how power is executed in a more subtle and

dispersed manner, hiding in regulations, policies and political decision-making. In our "modern" society – meaning: based on democracy rather than a feudal or totalitarian system for example – authority needs to find another way to operate. Governmentality's mechanism works as an "ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power" (Foucault 1979: 20). Neoliberal ideology is thus not singular and in one place, but rather takes on different shapes, spread through our institutions, policies and regulations. Although neoliberalism also functions as an overarching and coherent ideology, its manifestations have been "mutating over time" and can vary per country (Brady 2016: 17). It is for this reason that the manifestations of neoliberalism will be identified in the Dutch context in this thesis.

Foregrounding the Financial Value of Care

Because neoliberalism does not merely function as a separate set of ideas, but rather is integrated into the institutions. Through these mechanisms of governmentality, neoliberalism reinforces itself and functions as a *dominant discourse*. It represents the ideas, values and perspectives that are widely accepted and legitimized by those in positions of power. It shapes policies and political decision-making, while being presented as a neutral. Within anthropology however, we recognize that policies and other governmental practices are never neutral. Rather, they are a "generative realm of cultural production, producing and shaped by values, norms, identities, and practices" (Tate 2020: 85). Policies and such are inevitably shaped by political ideology. Through governmentality, policies work as a vehicle for neoliberalism. It changes the organization or structure of, in this case, care, and the way it is thought about.

Neoliberalism "develops institutional practices" and on top of that "rewards for enacting this vision (Brown 2003:1). Decades of focus on cost-efficiency in Dutch care, have led to what Keshavjee (2014) calls *neoliberal programmatic blindness*. As neoliberalism reinforces itself through institutions, the commitment to this ideology overshadows the initial goal of ensuring good and accessible care to citizens. It frames behaviour of the government and other institutions. "Rather than formulating policies to ensure full employment and an inclusive social welfare system, governments are now focused on enhancing economic efficiency and competitiveness. One consequence is the 'rolling back' of welfare state activities, and a new emphasis on market provisioning of formerly 'public' goods and services" (Larner 2006: 201). The commitment to cost-efficiency by the Dutch government, expressed in a long history of austerity measures, deregulation of care and the implementation of market-competition, has resulted in the *outsourcing* of care. Mellin show this outsourcing of care services from the Dutch government towards a complex network of commercial and non-profit organizations, where the government is no longer the provider of care, but rather the negotiator with third parties. This increasing use of third parties to deliver social services such as care, is what Milward & Provan

(2000) call a *hollow state*. This phenomenon obscures the responsibility of the government to ensure good and accessible care due to the large interferences of other parties. It "complexifies coordination and accountability", giving rise to output measures and practices of quality control (Milward & Provan 2000: 364). These institutional practices of measuring results and controlling quality are again shaped by norms and values. They are "deeply linked to a moral vision of government that values market-based solutions to social problems" (Mulligan 2010: 307).

Institutional practices, from policy-making to quality control, that are presented as neural practices "reproduce hierarchy of value through [their] implementation" (Tate 2020: 85). Such governmental and institutional practices carrying a focus on cost-efficiency, inexplicitly propagating neoliberalism, foreground the financial value of care that overshadows other societal values of care.

Methodological Framework

Multi-sited Ethnography and an In-Depth Case

This ethnographic research has taken the shape of multi-sited ethnography in combination with an in-dept case. My mother's story, initially just serving as a starting point, has brought thorough qualitative insights to this research. Her and her old colleague formed the focus group and served to deepen this experience. The other participants similarly worked as *direct* careworkers over a variety of sectors within the field of carework, mainly long-term care such as elderly care, disabled care and home care. With the exception of two, all research participants, including my mother and her colleagues, all had thirty to forty years of experience in the care sector. Besides the focus group, all careworkers were unconnected and worked in care organizations all over the country. It is for this reason that this thesis does not work with a single-site location. I explore the way people are connected through networks, systems and structures that spreads through multiple sites, rather than a singular territorial place. It makes us realise that "objects, people, information, goods and ideas are in constant motion, and, moving away from territorial constraints, they come closer to an open, global whole" (Turai 2018: 439). Therefore, also research methods can no longer be static. I draw upon Gusterson (1997) that describes a *polymorphous engagement*, that goes even beyond the physicality of locations. It refers to "interacting with informants across a number of dispersed sites, not just in local communities, and sometimes in virtual form; and it means collecting data eclectically from a disparate array of sources in many different ways" (Gusterson 1997: 116). Similarly, for this research I draw upon literature and news article, participants from various locations, and online expressions of careworker such as in Facebook groups into account.

Methodological Reflections

I have conducted this research with a mixed methods approach. Through *triangulation* I have combined qualitative and quantitative methods. This implies that the qualitative methods have been "cross-checked" by quantitative methods and vice versa (Bryman 2016: 643). I have designed a synthesis of methods consisting of *online analysis*, *semi-structured interviews*, *lifeline drawings*, *participant observation*, *focus group*, *photo-elicitation* and a *questionnaire*. This combination of various methods has been established within the context of a multi-sited ethnographic field. I did not work with a clearly demarcated community situated in one place. Rather, I researched spatially dispersed individuals that find themselves operating in the same system, the Dutch healthcare system. Consequently, they are bound by their experiences as careworkers, both positive and negative. With this synthesis of mixed methods, I have tried to provide a stable ground for researching the multiple sites in both time and space, by covering both online and offline spaces, and by providing past, recent and current developments and experiences within the Dutch healthcare system and its careworkers. I will first elaborate on this synthesis of methods, after which I will discuss and reflect on each method

individually.
I started this research with an open orientation on *online* expressions by careworkers concerning the current state of Dutch healthcare. Through social media and news articles I collected the most commonly expressed, piercing problems currently experienced by careworkers in my fieldnotes. Initially just anticipated as a way to gain participants, the online world appeared to be a relevant field of study in itself. It served as a base for creating topics for the first *interviews* with participants. The interviews were planned and executed as semi-structured, to allow both prepared topics and questions, as well as give space to unexpected relevancies. During the interviews, I integrated *lifeline drawing*. As most of my participants carry 40 years of care work experience and memories, the drawings supported them in organizing their thoughts.
Initially, *participant observation* was not integrated into the preparations of this research due to uncertainties with ethical concerns and feasibility. In the end however, I did manage to participate in a day care for early-staged dementing elderly. This method did not only provide valuable data in itself, but also provided a space to verify insights gained up until then and created new substance for the methods that followed.
The *focus group* was supposed to take up a larger space in this research, but had to be narrowed down due to the practicalities of unmatching agendas in a relatively short time span. However, because it was planned relatively late, I did have the opportunity to prepare and structure it well, targeting specific issues in need of excavating that other research practices did not allow for. In this focus group meeting, I integrated a *photo-elicitation* to invoke memories and sentiments amongst the group of old colleagues.
Lastly, I conducted an online *questionnaire* based on previous insights and remaining questions. The questionnaire provides a verification of the qualitative data on a larger scale. In turn, results from this questionnaire guided the final additions for the last interviews.

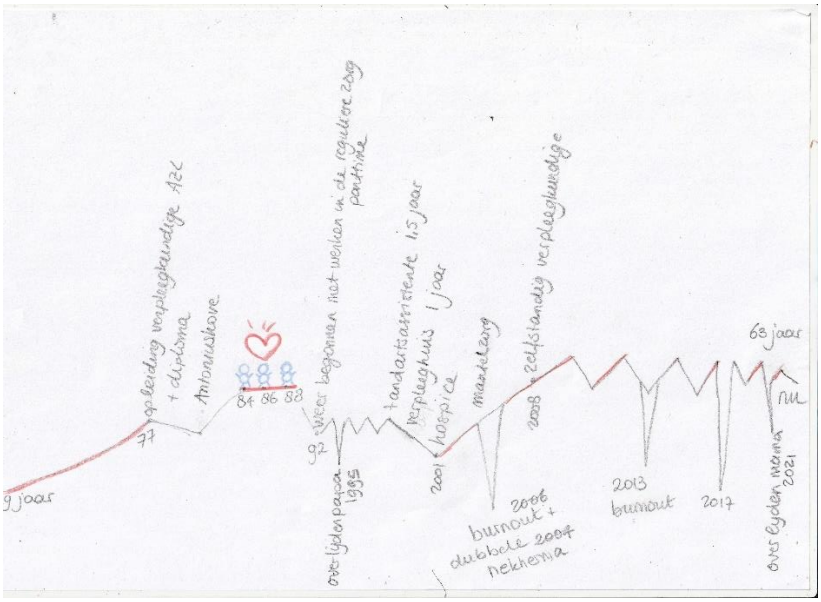
Semi-structured Interviews

The interviews have been shaped in a semi-structured, “open-ended, but follows a general script and covers a list of topics” (Bernard 2006: 210). It provides basic guidance through prepared questions and topics, as well as to dive further into spontaneous or unexpected points of interest that derive from conversation between interviewer and interviewee. It is exactly this unstructured element in the interview, that supports generating the “lived experience” of careworkers (Bernard 2006: 213). The flexibility in the interviews gave space to interviewees to deviate the conversation into issues they consider important, while the structure offers a certain time management, adjusting and redirecting the conversation when necessary. This way, I acknowledge interviews as not only a collaboration between interviewer and interviewee, but also as a “meaning-making experience for both” (Hiller & Diluzio 2004: 2). I have explained the objectives of the research and opened up space for questions about it on their side. Additionally, information sheets and informed consent forms were read and signed

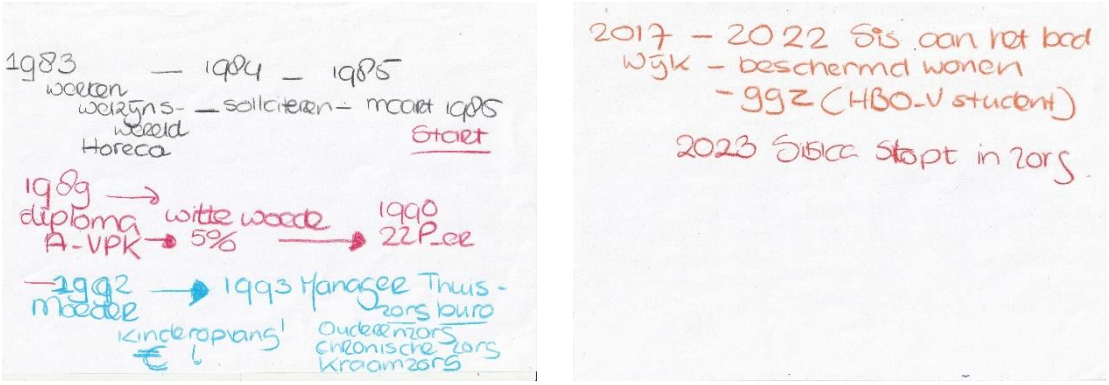
beforehand in order to ensure legitimate informed consent. I also paid attention to the motivations of my interviewees to engage with this research, as understanding their objectives helped to reflect on our collaborative meaning-making. During the interviews, I regularly repeated, rephrased or summarised their answers, in order to verify my understanding of their story, allowing them to correct me whenever necessary. Such reflexivity also aims at the importance of helping interviewees to further understand their own thoughts and behaviours beyond their first statements (Hiller & Diluzio 2004: 20). It is, however, important to realise that the interview will still be framed by the interviewer (Hiller & Diluzio 2004: 6). Which is why recognising the collaborative dynamic and integrating reflexivity into the process of interviewing is of greatest importance, as interviewers take up the role of portraying the interviewee's story.

Lifeline Drawings

As I aimed to research the developments in carework, from roughly the early 1980s till now, and the careworkers' experiences regarding these developments, I asked my participants to reflect on this time period. During the interview, participants were given the option to draw a line on paper, representing the time from birth, school or the start of their career up until now. On that line they were asked to mark important moments in their lives, with specific attention to their career. Such moments could include the start of a study or new job, the birth of children, a burnout, financial struggle or moving to another city. Also developments on a larger scale, such as a merging of two companies, an economic crisis or Covid-19. By allowing participants to visualise and write down their life events, they are encouraged to engage with their memories and actively structure their thoughts. This method does not only increase engagement in the interview, but also stimulates other parts of the brain. "Focusing on the visual level allows people to go beyond a verbal mode of thinking, and this may help include wider dimensions of experience, which one would perhaps neglect otherwise" (Bagnoli 2009: 565-566). It was particularly useful as some participants had over 40 years of experience in the care sector, but in general it also worked as a "touch point for further and deeper reflections" (Guenette & Marshall 2009: 87). The lifeline drawings invited participants to "enter into a reflective space and engage their stories with a depth that might not happen without such a representational activity" (Guenette & Marshall 2009: 92). Those who used this method during the interview, expressed that it indeed helped their thought process when talking about past experiences. The process of drawing and visualising encourages the participant to organize and be more reflective of their thoughts, ideas and memories surrounding topic of carework and their role in it. By creating a visual representation of their work history, I aimed to understand how personal and structural factors have influenced carework related experiences and decisions. Lifeline drawings where participants were asked to write or draw both micro, meso and macro level events, helped to identify patterns amongst my participants regarding their personal experiences, decisions and how this related to organizational and legal developments in the Dutch healthcare system.



Lifeline drawing 1: The participant drew her life with its ups and downs.



Lifeline drawing 2, page 1 and 4: The participant drew her life over four A4 papers

Participant Observation

This method was not mentioned in the proposal due to uncertainties about feasibility and ethical concerns. I considered access to care spaces that are already working with a lack of staff and time, and entering the physical and emotional intimate space of patients, as described earlier, in a short time period of 10 weeks ethically questionable. However, I ended up getting a “green light” from the daycare for dementing elderly that is separate from, yet integrated into a nursing home in the Randstad of the Netherlands. The physically intimate space, encountered during showering and toileting for example, is already largely eliminated in daycare, making it more accessible for medically unqualified ethnographers as myself.

Even though largely reliant on interviews and its visual elaborations, participant observation played a significant role in this research. When engaging with issues of care and what it entails, it was of great importance for me to understand the act of caregiving in a professional setting. As we have all taken care of somebody to some extent, whether it be your children or doing groceries for your sick friend. But caretaking as a paid profession, as an 8-hour workday and you being legally responsible, is a whole different dimension. Even though I could never recreate the experience of a full-time careworker, it did give me a hint of insight into the emotional labour and empowerment that comes along with it. By experiencing the – yes, sometimes personal – attachment to patients, developed in such a short period of time, helped me to understand both the joy and satisfaction, as well as the emotional and energetic drainage of the job. This experience helped to place the data collected from less direct methods such as interviews and the questionnaire. Participant observation "helps to understand the meaning of your observations" (Bernard 2006: 355). It touches upon the mixed methods approach of triangulation with which the quantitative and qualitative data extend each other's validity. "[They] inform each other and produce insight and understanding in a way that cannot be duplicated by either approach alone" (Bernard 2006: 356).

The participant observation was designed in the style of *participatory rapid assessment* (Bernard 2006: 352). This strategy is often adopted when long-term fieldwork is not feasible. It means that the participant observation has been prepared in a targeted way, with a set of questions or topics one wants to collect data about. My objectives at the daycare were to a) participate in the act of professional caregiving in order to enhance my understanding of the careworkers' experience, b) touch upon the issue of what care means beyond the physical and into the realm of emotional intimacy, c) explore and capture the latter issue through the visual method. The method of targeted participant observation, or participatory rapid assessment, made this type of fieldwork feasible within its constraints.

Focus Group: Photo-elicitation, Mapping, Walking Ethnography

In the proposal I planned three focus group meetings, after doing an individual interview with each member first, in order to grasp their individual backgrounds, experiences and stance towards the topic. Unfortunately, the three meetings appeared unfeasible due to their four busy schedules, being able to plan the first meeting only in the second last week of fieldwork. The focus group ended up taking a less prominent space in the fieldwork as intended, yet was still of great value and created space for the previously unintended participant observation. Because the focus group meeting took place relatively late in the fieldwork period, I was able to implement findings from other research methods up until then. I structured the meeting alongside specific methods, involving photo-elicitation, mapping and walking ethnography, and targeted questions, topics and discussion points.

I started off with a spontaneous first greeting amongst the old colleagues, letting their interactions flow naturally. When they settled down with a cup of tea or coffee on the couch, they already started to

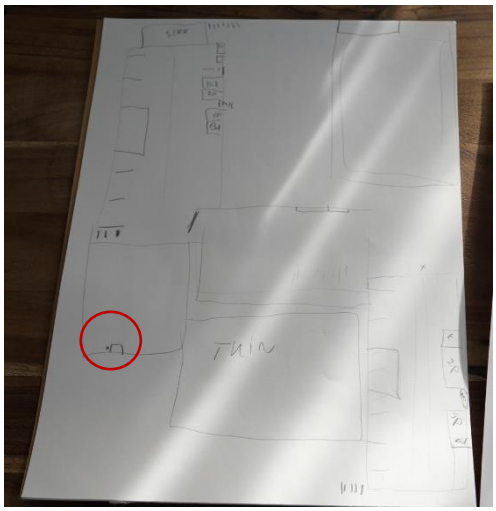
share the pictures and documents I asked them to bring. I picked up on this and led it into the *photo-elicitation* as planned. The pictures and documents, like their diplomas and check-books, are visual and tangible components that stimulate different parts of the brain than written or spoken words would. Images help to connect or reconnect an individual to their experiences, thereby evoking memories along the way (Harper 2010: 13). The photo-elicitation helped to recall experiences and stories of my participants and their time together at Lozerhof in the late 1970s early 1980s. Their conversations and interactions gave a sense of what caregiving practices and its organization, and the dynamic between the colleagues looked like at that time, while simultaneously pointing out the differences with more recent experiences in their carework.

Photo-elicitation; screenshots from the film:

A) The nurses' headquarters at De Lozerhof, 1980. In this case, the picture illustrated earlier descriptions by the participants.

B) Diploma and pins from graduation. The dates on the documents helped the participants to order their thoughts.

Next, I invited them to draw a map of the nursing home building they used to work in. This way, I used *mapping* as an "ethnographic way to explore the landscape of […] memory" (Grasseni 2013: 97). Drawing a map evoked memories tied to specific places in the building. As Grassini (2013) mentions, "the association of specific places with social practice and the historical and economic traces [are] inscribed in the landscape", or in this case in the building (Grasseni 2013: 107). Certain departments, rooms and objects were drawn in great detail, eliciting new stories tied to those details. For example, when drawing, one of the participants remembered there was a sink in that room, which evoked a story they all remembered after the sink was addressed (see picture below).



Map made by the focus group:
In the red circle you can see what represents the sink. When one of the participants drew the room and remembered there was a sink, suddenly a story surrounding that sick came to mind amongst another participant. That sink had once been destroyed by a patient during a psychotic episode.

As there were some friendly disagreements on the structure of the building, I suggested taking a walk to the building, or rather the remains of it, as it was only a 15-minute walk from our meeting point. The walk to and around the building blew in some fresh energy through the physically active engagement with the environment. On top of again evoking memories and experiences in a different way, reconnecting the past and the present, the *ethnographic walk* helped to attend to the lived relationship the participants had with this building. The active engagement with their environment, walking around the building, pointing and talking about particularities, goes beyond evoking memories. The ethnographic walk opens up a "performative space" where the participants could "take on, bend and respond to the many histories, questions and meanings that might be associated with to particular locales" (Moretti 2016: 96). The old nursing home building, or the carcass left of it, helped to reconnect the participants with that time period and each other.

The ethnographic walk around the building.

A) 'De Lozerhof' building that is about to be torn down.

B) Focus group participant pointing at the office of the doctor's assistants.

All three visual methods, photo-elicitation, mapping and ethnographic walk, were aimed to "not simply evoke more information, but rather a different kind of information" (Harper 2010: 13). As I worked both with past and present experiences in care work, the visual component touches human

consciousness on a different level, using present objects (picture, map, building) to connect and evoke memories of the past.

The last part of the focus group meeting was shaped as a discussion. I printed and cut out statements on paper for them to talk through. The statements had been based on previous findings through the methods of online analysis, interviews and participant observation. They contained topics in need of further elaboration and new questions that arose from answers. The statements have often been phrased in the opposite way than the findings showed, in order to provoke discussion. For example, through the interviews it quickly became clear that most participants were not satisfied with certain developments and decisions in the care system made by the government. The statement would then be phrased like "The government has made good decisions with regards to improving the healthcare system in the past decennia". Appendix […] is an overview of the discussion points that have been used in the focus group meeting. The statements helped to start a more abstract dialogue about the topic of care, the system they worked and work in and how it affected and still affects their job as careworkers. The discussion helped to connect the individual experiences of my participants to larger socio-economic structures.

Beyond the integration of various visual methods, the value of the focus group meeting finds itself in the interactions and conversations *between* careworkers. Even though the group interactions are still mediated by me as the ethnographer, my role during the conversations was less prominent than with one-to-one interviews. In the focus group format, the participants were often carrying the conversations themselves, asking each other questions, sharing different opinions, and hooking upon each other's stories. It stimulated active engagement with both the current and past situation of care in the Dutch health care system. The participants build upon each other's experiences, creating a more holistic picture for me as an ethnographer. The focus group was used to "find out why people feel as they do about something or the steps that people go through in making decisions" (Bernard 2006: 234). With this I wanted to generate a "thick" qualitative understanding of the experiences of careworkers in the Dutch care system. Simultaneously, it provided insights for shaping the questionnaire (Bernard 2006: 233). Partially, statements used in the focus group have been used in the questionnaire as well.

Questionnaire

The questionnaire is a quantitative method that I used to verify the findings from qualitative methods on a larger scale. The questionnaire has been formed towards the end of the fieldwork period, when patterns and conclusions slowly started to form. The most important findings have been translated into mainly closed questions, statements with agree-disagree options, and three open questions. I have implemented the questionnaire to enlarge the representation of the research. Additionally, the answers

of the first respondents to the questionnaire, the patterns and outliers, have been integrated into the very last interviews to verify with qualitative data.

The questionnaire has not been filled in by participants that already participated in the other research methods in order to prevent a repetition of answers and overlap in voices. The self-administered questionnaire has been mainly been spread through online platforms like open and private Facebook groups, LinkedIn or directly via email. Additionally, QR codes linking to the questionnaire have been printed and handed out during the protest. These ways, careworkers were able to fill in the questionnaire in their own time and pace. The questionnaire was conducted anonymously. This anonymity provides a “sense of security”, create a safe space for honest answers, allowing for possible critique or sensitivities (Bernard 2006: 260). However, at the end of the questionnaire there was an option to leave an email address to be kept updated on the final result of the research. Lastly, there was space for the respondents to leave any remarks, questions or concerns with regards to the questionnaire. (View full report in Appendix).

Ethical Considerations

Ethics in anthropological fieldwork and research does not have a one-size-fits-all format. Its objectives and official guidelines shift through time and context (Bernard 2006: 75). Yet, as a discipline and thus also in this research, we adhere to the AAA Code of Ethics (2012). The seven principles of professional responsibility are as follows:

1) Do No Harm;
2) Be Open and Honest Regarding Your Work;
3) Obtain Informed Consent and Necessary Permissions;
4) Weigh Competing Ethical Obligations Due Collaborators and Affected Parties;
5) Make Your Results Accessible;
6) Protest and Preserve Your Records;
7) Maintain Respectful and Ethical Professional Relationships.

The AAA Code of Ethics are a good foundation for the conduction of fieldwork and anthropological research, but it does not yet shape the practical realization of ethics, as this is also very much dependent on the context of the research. Ethics need to be considered and integrated as a method or practice in scientific research (Bernard 2006: 26). I have done so by keeping open and clear communication with my participants with regard to the research objectives, what they can expect from me and what I expect from them. I have done this on multiple occasions both verbally and with forms.

Data management

Audio-visual material and other raw data have been stored on a hard-drive and a back-up hard-drive. No cloud storage has been used for protection and confidentiality (Lawrence 2020: 27). Raw data and material will not be shared with third parties. Data management and storage principles have been shared with participants.

Informed Consent

Prior to participation, information sheets with summarised objectives and expectations of the research, along with a short explanation of this MSc and contact information have been handed out to participants. There was space to express questions and uncertainties. After agreement to participation, participants signed an informed consent form for participation to either only fully anonymised analytical purposes or both for analytical purpose and the visual output that is per definition not anonymous.[5]

[5] See Appendix

Audio-visual Considerations

When creating an audio-visual output such as a film, it is important to think about three components and our responsibility towards them. As audio-visual researchers and creators, we have to "[balance the] act between their ethical responsibility to their subjects, to themselves, and to their viewers' (Barbash 1997: 49). The possible impact of the audio-visual output on both the participants and the viewer need to be taken as the responsibility of the researcher both during the process of making the film, as well as after with regards to distribution.

During the process of filming and editing, active attention has been dedicated to guaranteeing the privacy of patients at the daycare. Agreements had been made with the careworkers of the daycare, where full face shots and names of patients, as well as the name and place of the organization had to be eliminated from the film. Before the official screening, this has been checked by one of the daycare careworkers.

Additionally, a trial screening has been organized for the film participants, prior to the final cut of the film. This is to account for any possible differences between the presumed and actual outcome of image display and give them an opportunity to have a say during, rather than after the editing process (Marion & Crowder 2013: 6). After the screening, participants agreed through a media release sheet (see appendix) for screening during the LUVE Festival. For further future releases, participants will be consulted for permission.

Close Ethnography

It is inevitable to acknowledge the relationship between me and Inge as mother and daughter, both in the practice of ethnographic methods as well as in the film. As ethnographers, we have to balance the personal and professional aspects in our roles with regards to our participants and methods. "We navigate membership, participating, observing, and observing our participation" (Tillmann-Healy 2003: 732). Due to our deeply personal relation and shared history, Inge's participation in the research had a different ratio than other participants. Formal and informal methods intertwine. I draw upon Tillmann-Healy (2003) who addresses *friendship as a method*. Similarly to friendship, there already is a close relationship with open conversation. In these less formal relationships, whether it be friendship or relatives, "our primary procedures are those we use to build and sustain friendship: conversation, everyday involvement, compassion, giving, and vulnerability" (Tillmann-Healy 2003: 734). Even though I held two formal interviews with my mother, a large part of the data gathered from her experience, formed through informal, everyday interactions. In these cases, the method of data gathering happened organically, "in the ebb and flow of everyday life"(Tillmann-Healy 2003: 735). Rather than ignoring or problematizing the issue of my mother as both the main protagonist in my film and participant in my research, I explicitly acknowledge our intimate relationship. It does, however, ask for another type of ethic, one of "caring that invites expressiveness, emotion and empathy"

(Owton & Allen-Collinson 2014: 285). To this, I want to add a stance of responsibility that diserves extra attention, since emotions and sentiments flow more freely in intimate relationships. Close ethnography, "performing" ethnography with close ones, makes us realise how the personal and professional aspects intertwine and help us to acknowledge the fluidity and constant negotiation of our roles as ethnographers.

Ethnographic Analysis

PART I: Neoliberalism in Dutch health care

The Arrival of Neoliberalism

First, it is important to understand how neoliberalism has manifested itself in the Netherlands and its healthcare system, in order to understand its impact. Mellink and Oudenapsen (2021) identify the emergence of neoliberal ideas settling in the Netherlands can be traced back to the 1930s when the crisis gave space to alternatives. It is notable that these ideas circulated not directly amongst politicians, but in a network of scientists, journalists, civil servants and entrepreneurs. They did however all have political intentions, lobbying politicians or through newspapers. This starting point of neoliberalism in the Netherlands is important because it became known to a wide public without explicitly being linked to an ideology. It explains how, as a consequence, neoliberalism has been able to move through the capillaries of the Dutch political landscape without much notice. As the early Dutch neoliberals did not believe in political parties, but in ideas, they also never established an explicit neoliberal party. Rather they "strived to exert influence amongst the already established institutions" (Mellink & Oudenampsen 2021: 10).

It is here where we can see the workings of neoliberalism through the mechanism of governmentality. Rather than an explicit party that can be chosen by citizens, neoliberal ideas were spread through a network of advisors and civil servants to several institutions in or surrounding the government, such as the Ministry of Economics. The explicit politics of Reagan in the US and Thatcher in the UK did not find ground in Dutch politics due to a different political culture that is based on consultations and compromises. Explicit ideologically based politics would not attract a majority of votes (Mellink & Oudenampsen 2021: 141) Rather, Mellink and Oudenampsen argue, Dutch economists had a central role in settling neoliberal thought into governing institutions. They did this by presenting neoliberal ideas as "objectively established principles of economics" (Mellink & Oudenampsen 2021: 142). They extracted the ideological and political factors from neoliberal ideas. This is the process of *depoliticization*, where issues are framed as technical problems in need to be solved, rather than political questions that involve ideologies and values. Through governmentality, neoliberal principles are presented as economic matters that are objective, neutral and beyond political debate. Consequently, neoliberal governing has been executed not just by right-wing coalitions, but also purple or even left-wing cabinets. Presented as the most rational and objectively best option, neoliberalism serves as the *dominant discourse* shaping the political decisions, policies and the values behind them.

Contextualising the "Participation Society"

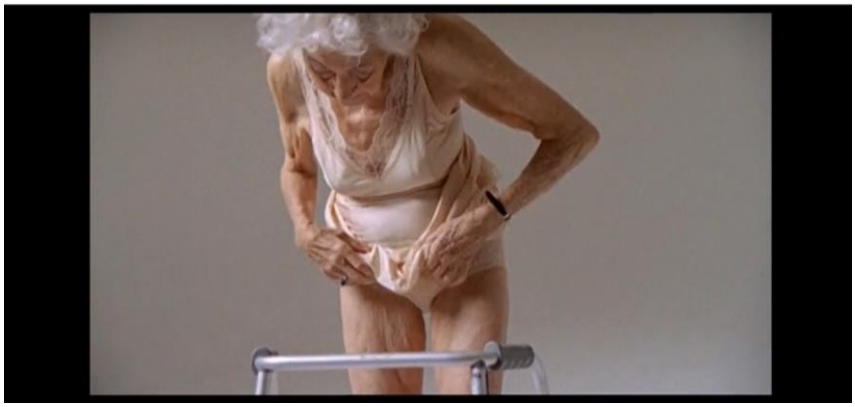
After the ruins of WWII, the Netherlands was rebuilt and expanded into a full welfare state by the late 60s, providing social security for its citizens. Although neoliberal ideas spread since the 1930s, neoliberalism started to be actively implemented in Dutch politics not until after the oil crisis of 1973 and the stagflation that came as a consequence. The care policies now focused on cost-efficiency (Bertens & Palamar 2021: 69). In the 1980s and 1990s, policies were guided by deregulation, decentralisation and privatization, ultimately leading to a market-reform of the care system in 2006. The market-reform and its 'regulated competition' was implemented with the primary goal of reducing costs (Bertens & Palamar 2021: 11). The deregulation that came paired with this, supposed to reduce government interference, led to decisions that moved the regulation of certain care sectors to other institutional organs, such as youth and home care that went to municipalities. On top of that, the market-reform facilitated external parties with a profit motive to enter the care system (Melling & Oudenampsen 2021: 241). While the government remains legally responsible, these actions of *outsourcing* falter the government's capacity to ensure access to good quality care for its citizens. Consequently expanding output measurement and quality control practices. These neoliberal governing practices, disguised from their ideological roots by being presented as neutral and matter-of-fact necessities, have led to a retrenchment of the welfare state and has been replaced by what the Dutch government now formulates as a 'participation society'.

The change in language represents a change of attitude towards care. The arrival of neoliberalism in the Dutch government was accompanied by a business attitude that favoured results and slowly shifted the governmental responsibility of care towards individual responsibility. The shift towards a "participation society" insinuates that the care one deserves depends on one's active participation in society and is conditional rather than a basic right. The use of words like "participation, [are] not a neutral term[s] and does not necessarily equate to access to health care" (Browner 2019: 456). We see this paradigm shift in the government's emphasis on "self-reliance" in care, encouraging patients in need of long-term care to remain at home for as long as possible. The term is used with an unclear definition of what this entails and leaves us with a lot of questions for those less or unable to "participate" in society, such as chronically ill, elderly and disabled (Sakellariou & Rotarou (2017)). Rather, the use of these words seem to express the neoliberal value of individual responsibility and used to explain the reduced professional care for patients as a consequence of austerity measures due to the cost-efficiency focus[6].

We find neoliberalism in the Dutch care system not only through the explicit focus on cost-efficiency in governing practices such as deregulation and market-reform, but also in the depoliticised business attitude and a shift towards individual responsibility.

[6] https://www.zorgwelzijn.nl/zelfredzaamheid-betekent-dat-je-hulp-niet-krijgt-2677257w/

PART II: A Fragmentised System



Dan kan ik me net zo goed voor heel Nederland uitkleden (29-07-2009)
Commercial political party SP: Voor een menselijke thuiszorg.
https://vimeo.com/108112316

Above is a still from a commercial from the political party SP in 2009 to which one of my participants, Leonie[7], contributed. During our interview, her activistic heart becomes clear to me quite quickly. Leonie started working in care in the 1980s, joining the 'Witte Woede' ('White Anger') in 1989 for better salary and working conditions. She covered various sectors such as home care, elderly care, hospital and maternity care; she worked her way up to management positions, and even into politics fighting the negative consequences of the market-reform in 2006; Eventually, she went back to direct care practices as that was where her heart lay, but now, even though physically and mentally capable, she doesn't work anymore – out of protest. "I have done *a lot* to prevent or reverse the developments in care that worked against careworkers and the quality of care. Now I pass the baton to the next generation". I sense a certain defeat, a painful acceptance.

I ask Leonie what she's most proud of in her activistic career. She shows me the video she helped to develop. [Click to watch: https://vimeo.com/108112316] "*For years I have been helped with washing by Connie. But she's too expensive, they say. So now they send me a stranger. And after that, another stranger. I might as well undress myself for the entire country*". The video addresses how the patient's regular careworker is being replaced by "strangers". It illustrates a development in Dutch care where permanent careworkers have been replaced by other – cheaper – workforces. It is a development that other participants recognize. The careworkers explain to me how back in the day, they used to do everything themselves: from washing to breakfast, from playing board games to toileting, from cleaning the patient's room to going on a patient holiday[8]. Over the decades, these care practices have been segregated into separate tasks, executed by separate careworkers. There is a separate cleaner, a

[7] Name changed due to safety reasons.
[8] Staff and patients from a nursing home for example going out for a day or weekend together.

careworker who brings around breakfast, another that does washing and wound care etc. These practices of separation remind us of a Fordist approach to achieve efficiency in order to maximize profit. These fragmentations of care practices have slowly been shaped this way through a series of regulations and policies, but the market-reform of 2006 has underscored this phenomenon. One of my participants, who started as a direct careworker in somatic care, now works in the finance department of a care organization. He sells the care the organization can offer to insurance companies and negotiates prices. He explained to me how each care practice, from giving a meal to an operation, is isolated, coded and given a specific price. This approach to care is indicative of how care is no longer seen as a holistic practice that works with humans, like the woman in the video, but rather as a product that needs to be produced efficiently in order to minimise expenses or even generate a profit.

Cheaper alternatives: familial care, volunteers, recruiting foreign careworkers

Additionally to a fragmentation in care tasks, we also see a fragmentation in who performs the care practices. In line with the cost-efficiency attitude, we can see how more care tasks are shifted towards cheaper alternatives, such as volunteers, familial care and foreign careworkers. Certain care organizations become more dependent on the deployment of volunteers. For example in the daycare for dementing elderly, they work with volunteers for driving the van for picking up the visitors as well as volunteers to support the one obliged care professional during their shift. “We are incredibly grateful for our volunteers and couldn’t do without them. But they are not a replacement for a care professional. And sometimes volunteers are an extra burden as we have to guide them as well”, says one of the careworkers at the daycare. Occasionally, it also leads to dangerous situations. As elderly people stay at home much longer nowadays, as promoted by the Dutch government, their conditions also worsen. The daycare worker tells me how one of the visitors became uneasy in the van, affecting the other elderly and causing panic and confusion. “Luckily it was on the way towards the daycare, so we professionals could act immediately when they arrived because the van driver had no idea how to deal with the situation.” Volunteers are indispensable in care, but cannot replace a careworker nor carry the responsibility for the patients.

Another trend we have been seeing is invoking familial care. As the Dutch government has been promoting elderly, disabled and chronically ill to stay at home as long as possible, as home care is considered cheaper than institutional care. It means that certain tasks fall on the shoulders of family, friends or other familiars. In the case of careworkers also providing familial care which was the case surprisingly often among my participants, it invokes an interesting point of question. In the case of Inge for example. She deliberately chooses to work only 3 days a week at the daycare, because she provides care for her dementing mother at least one day a week, if not two. Encouraging care receivers to stay at home for as long as possible, emphasising unpaid familial care before paid professional care, does not only withhold familial caregivers from spending that time on paid work, but also shifts responsibility to the individual, rather than care being provided and ensured by the government as a

basic right for its citizens. The increased deployment or encouragement of familial care by the Dutch government is a measure from which we can question whether this is actually meant to add to the improvement of care, or if the motives are mainly driven by cost-efficiency.

Rise of for-profit organizations

Another phenomenon that is in line with the trend of deploying cheaper labour, is the recruitment of foreign careworkers. One of my participants fell out of the picture of decades of experience in the Dutch care sector, but did have an experience resulting out of the mechanisms of neoliberalism in health care that I wanted to include. The participant, who wishes to remain fully anonymous due to legal agreements, came from southern Europe to the Netherlands through a programme of a recruitment company. In this programme, they would get accommodation, education, a job and a crash course Dutch. Presented as a great opportunity for foreign careworkers to get education and work experience in another country, little appeared to be true. The contracts of the recruitment company were constructed in such a way that they had no legal bounding or obligation to arrange any of this. My participant and ten others who joined the programme struggled for months to get their basic amenities. Promises such as job guarantees and transportation were not kept. They were mainly deployed in care fields where the lack of staff was highest, like elderly care, resulting in the execution of care tasks way below their capabilities and thus far from the new experiences they were promised. The careworkers were in a stranglehold with their contracts and minimum wages, resulting in a lawsuit where my participant is still paying the full price for breaking the contract. And this is not a single case, more foreign careworkers are recruited to the Netherlands under false terms. A large group of Indonesian careworkers are not educated as promised and work 40 hours workweeks out of which they only get paid 16 hours, as the others are considered "internship hours" while there is no difference in tasks.[9] "With the whole situation, it became very clear that they did not recruit us to give us an opportunity or to improve care, but rather to make money out of us. It's a business model", my participant expresses. We see an emergence of such companies that pick up on the holes in the care system.

Similarly, other for-profit organizations are rapidly gaining ground (Bos (2020)). For-profit care institutions, such as 'woonzorgcentra', roughly translating to residential care centres, that mimic the idea of a nursing home, but construct their construct their regulations strategically that they can cash both on rent and care, while cherry-picking only the lowest cost patients[10]. Neoliberal regulations that

[9] https://www.nu.nl/binnenland/6272816/indonesische-verpleegkundigen-worden-hier-uitgeknepen-ik-voel-me-opgelicht.html Consulted on 20-07-2023

[10] https://www.nrc.nl/nieuws/2022/11/03/tot-hoever-reikt-de-zorg-in-het-verpleeghuis-light-a4147178#:~:text=Onderzoek%20%7C%20Verpleeghuizen%20Nieuwe%20ketens%20van,niet%20te%20veel%20gebreken%20krijgen.&text=Kan%20dat%20zomaar%2C%20vroeg%20huisarts%20Marcel%20Janssen%20uit%20Waalre%20zich%20af Consulted on 17-11-22

deregulated long-term care and stimulated “self-reliance”, opened doors for companies to exploit loopholes in care system (Bos 2020: 439). The pattern of companies anticipating on these holes in the care system, such as recruitment companies and ‘woonzorgcentra’, fit the trend of care becoming a product to make profit off.

Another form of fragmentation arises in the shape of an increase in self-employed careworkers. They are a response to stressful working conditions and a lack of compensation for it. There is a trend amongst careworkers that first worked as permanent staff, to retreat and re-enter as self-employed with the advantages of choosing their own schedule, clients and price, tackling three common issues that lead careworkers into exhaustion. Self-employed careworkers can cherry-pick shifts, leaving tougher shifts to permanent staff that already experience high work pressure. Although understandable from the careworkers point of view, this phenomenon adds to the vicious cycle of working conditions for careworkers. Participants also refer to the importance of a well-functioning permanent team as a cornerstone of care practices. Something to which the increase in self-employed, temporary careworkers do not contribute.

The fragmentation of care that has arisen under neoliberal governing is an effect of a cost-efficiency focus and bypasses the initial goal of ensuring good care for citizens. We can understand this as a case of neoliberal programmatic blindness, where the adherence to neoliberal principles, such as cost-efficiency to minimize government spending, overshadows the goal of the Dutch government to deliver good and accessible care to its citizens. It has resulted in an fragmented, incoherent and complex system that works *against* careworkers, rather than supports them in the delivery of good care. Rather than investing in well-functioning teams and good working conditions, decisions are let by financial motives.

55 out of 61 respondents (90%) prefer working with a permanent team.

PART III: Cost-efficient Intimacy?

Daycare for Dementing Elderly: A Case for Emotional Intimacy

The first visitor walks in, way too early, clearly comfortable in the space, she greets everyone, hangs up her coat, and shuffles to her seat waiting to be served a coffee. Inge and her colleague are immediately activated into preparing the tea, coffee and biscuits, while a third colleague remains in the office with administrative tasks. Slowly the twelve visitors and two volunteers trickle in. The volume in the room rises while everybody gets settled with a beverage.

As everybody is chatting about the weather and local news, Inge sits beside Miss Anne. She is a quiet one, but today seems a little more absent-minded than usual. “What a lovely necklace you are wearing, Miss Anne.” She looks down on her chest and then at Inge, glassy, not knowing quite what to say. “Where did you get it?”, Inge continues. A short pause, staring at her necklace, and then the answer seemed to hit her. “My grandchild,” she said, “My grandchild gave it to me for my birthday.” “Well isn’t that sweet!” They continue talking about her grandchildren, clearly a topic that brightens her eyes. Somehow, Inge knew where to hit the right spot and put a smile on Miss Anne’s face.

Inge works at a daycare for elderly people with dementia in a nursing home in Leiden, the Netherlands. The daycare receives patients, deliberately called visitors, mainly from outside the nursing home, but who do have a diagnosis of dementia and official indication for daycare. As the Dutch government has put its policies towards staying at home for as long as possible and thus tightening the requirements for nursing homes, there is a large group of elderly, disabled and chronically ill who’s conditions are not considered “bad enough” to be placed in a nursing home or other care residence. The consequence that daycare workers see, is that the visitors at the daycare come in with heavier or more complex conditions, and drop out quickly. “Our groups change all the time now. The new people that come in often only come a few times, after which they have to go through crisis admission or even pass away already. They should have been placed in a nursing home already. We see their partners, who provide familial care, completely exhausted. But the waiting lists [for nursing homes] are long.”

When we think about professional, paid care, the first thing that often comes to mind are the physical acts of care like showering, toileting, and injury care. Those practices naturally enter an intimate space. They are activities one would normally do alone, in private. As patients are very much dependent on others in their daily activities, careworkers inevitably enter that private space. Patients’ homes, rooms, showers and toilets then have to become a safe space of mutual trust that is inherently intimate. But care is not only physically intimate. The ethnographic vignette above shows us another side of intimacy that care entails. It does not only entail a ‘taking care of but also a ‘caring for’, a mindful attention and interest in the patient; seeing and acknowledging them; listening to their needs

and wishes. In daycare, the physical component of care is less prominent, allowing us to focus on the emotional intimacy of care that is evident in all care practices. This is why I use daycare to show how carework functions as an inherently intimate practice that goes beyond the physical and emphasises the emotional intimacy that is found in all care practices.

As said before, the daycare I researched is for elderly with beginning stages of dementia. This daycare aims to offer patients a safe space for their visitors, provide structure in their daily and weekly routines, and offer low-key activities they can join, while also offering relief to their familial caregiver, often their lifelong partner, who takes care of them at home day in and day out.

The creation of a safe space can also be seen in the physicality of the room. The space used to be a two-person apartment in the nursing home it is placed, and thus already has a homely layout. This homeliness is emphasised in the decoration of the space. Material goods, such as decorations, carry a certain "socialness" and signal a "performance" of social relations within that space (Money 2007: 358). The rooms are filled with furniture one's grandparents typically could have at home, flowers are on the table and pictures and paintings are on the walls. It is only the ergonomic stools for the staff that give away the professional setting. Some of the decoration is dependent on the seasons and festivities. In late January the windows are decorated with '2023', there is a knitted snowman on the table, and cut-outs of polar bears and penguins hang on a chandelier. In February the windows are filled with red and pink hearts for Valentine's Day, and in March the daffodils are on the table. Equally, the activities are inspired by these seasonal changes or religious festivities, like making Christmas cards or painting Easter eggs, and are displayed in the room. Objects in a space hold "nonverbal expressions of thought, need, conditions or emotions" (Collier & Collier 1967: 46). The collectively crafted seasonal decorations carry a sense of togetherness, but also express the often disoriented state of the visitors. The seasonal decorations and other visual reminders such as the date on the fridge, provide visual references for the dementing elderly to hold on to and offer a sense of time that is often lacking or degrading in their condition.

The date and winter decorations on the fridge.

Easter decorations on the table.

The Importance of "Aandacht"

The vignette at the start of this part, we see the importance of 'aandacht' in care. The English translation of 'attention' does not fully cover its Dutch meaning. Yes, paying attention is an important part of care. "When you have ten to fifteen dementing elderly under your responsibility, you need to have eyes in your back." Making sure no one falls, that nobody is stealing more biscuits, but also paying attention to both each individual as well as the group dynamic as a whole. But 'aandacht' also contains a sense of 'presence' or 'awareness' towards a person, having sensors to visitors' moods and unspoken wishes and anticipating that, such as, offering a listening ear, giving a smile, or simply being there with the knowledge that you will always be within reach. Careworkers do not only take care of, but also care for their patients. This is the level of intimacy in care that requires *emotional capital*. It contains an expertise in *being*, *knowing* and *doing* that is integral to a careworker. It is a trained and embodied practice that is at the heart of carework and allows careworkers to know and act according to the patient's needs (Thompson et al. 2021: 5). "*Aandacht*" functions as an instrument with which careworkers deploy their emotional capital to create and maintain the *relational space* with their patients.

Decay of the Relational Space

What was most prominent amongst all participants, in the interviews, daycare as well as questionnaire, is that all indicate a lack of time in order to perform their care tasks. The following extraction of the questionnaire on the question "What is good care?" comprehends the overall thrust of the other respondents.

> "Good care: Enough 'aandacht' and time for patients during a shift. Lessen the administrative tasks. A permenet team that can develop themseves professionally in order to provide customised guidance for patients when necesarry. Having a say on the work floor to improve the primaire care. Protocols work against this sometimes."

Care is performed with "time and 'aandacht'". Of course careworkers differ in their opinions and nuances on how to deliver the best care, but the need of time in order to perform their profession was almost unanimous. Time is needed to give "aandacht"; to deploy their emotional capital. "Aandacht" and thus time are a cornerstone of care as an inherently intimate practice. Acting from expertise, a *being*, *knowing* and *doing*, requires a certain flexibility and trust in careworkers to be able to attend to the needs of their patients and the time necessary for this. The neoliberal focus on cost-efficiency that has shaped care policies over the past decades in such a way that there is too little time to perform care in with "aandacht" that is essential to the creation and maintenance of the relational space essential to care giving practices.

Similarly, the increase in administrative tasks for careworkers infringes on that relational space. As a consequence of the fragmentation, outsourcing and a business focus on results, output measuring has

been expanded, resulting in more administrative tasks. “All the time I spend on reporting what I have done, I would rather spend on direct contact with my client,” multiple participants tell me. “Some things definitely need to be written down, but right now there is too much unnecessary administration. It is like they don’t trust us, but we are the professionals here.” The amount of reporting is a daily burden for most careworkers.

Careworkers experience that a majority of policies and regulations do not support them or their care practice. While recognising that certain regulations and efficiencies are definitely necessary, especially considering the aging population, careworkers experience too many obstacles in the performance of their care and the deployment of their expertise. It has resulted is several calls for help towards the Dutch government, ultimately calling the current situation a ‘care infarct’. Scepticism and distrust in the Dutch government is expressed on social media platforms.

Resentment toward the government is commonly expressed on Facebook groups. Comment: “With this bunch in The Hague [government], you can’t count on anything. Only misery.”

The current organization of care does not facilitate the deployment of emotional capital, while it remains inherently essential to the job. Careworkers are then unable to give the care they want or are expected to deliver. Consequently, knowing that emotional capital has two sides, it causes an imbalance between emotional labour and emotional empowerment, out of which then the first one prevails. As illustrated by the respondents of the questionnaire below, it leaves careworkers overstressed or even exhausted, adding to the already vicious cycle of lack of staff.

I feel mentally/emotionally burdened after a workday: 49 out of 61 respondents agree (80%).

Conclusion

In this thesis we have seen how neoliberalism established itself in Dutch governing practices regarding healthcare through the mechanisms of governmentality. Over the past decades it has served as a dominant discourse, manifesting into existing governmental institutions by a network of economists, entrepreneurs, advisors and journalists with political purpose. Rather than functioning as a separate political party explicitly based on neoliberal ideology, neoliberal ideas and principles have been depoliticized and presented as neutral, matter-of-fact economics. In the Dutch care system, we have seen neoliberal manifestations through governing practices like privatization, deregulation and an market-reform with regulated market-competition, implemented with an explicit focus on cost-efficiency (Bertens & Palamar 2021: 12).

Consequently we see a fragmentation of care tasks that are coded and prices separately, making care into a product that needs to be sold rather than a right provided by the state. A labour division that reminds us of a Fordist approach to achieve cost-efficiency. A flexibility on the labour market, with temporary staff and self-employed careworkers, deteriorate good functioning permanent teams. The fragmentation of care can also be found in a shift towards cheaper alternatives of certain care practices, such as familial care and deployments of volunteers and a rise of for-profit organizations, such as recruitment companies and “woonzorgcentra”. The fragmentation of care indicates how care is no longer approached as a holistic practice.

I have shown care practices to be inherently intimate on both a physical and emotional level. Careworkers deploy their emotional capital, using “aandacht” as an emic concept, in order to create and maintain a relational space between careworker and care receiver in which those intimate practices take place. A dissatisfaction amongst careworkers, not new but recently more prominent in news outputs, expresses how a lack of time and increase in output measurements are in the way of deploying their emotional capital. The current fragmentized organization of care does not facilitate the creation and maintenance of the relational space that is essential to care practices, causing a field of tension due to a disparity between the care careworkers are able to give versus the care they want and are trained to give.

Policies and other governing practices do not come neutral, but are “shaped by values, norms, identities and practices” (Tate 2020: 85). I want to make clear that the explicit focus on cost-efficiency by the Dutch government - and thereby the choice to not invest in care - is not a mere objective necessity, but a political choice grounded in neoliberal ideology. Adhering to the principles of neoliberalism then becomes an objective in itself, overshadowing the goal to ensure access to good quality care for citizens. I argue that this neoliberal programmatic blindness extents to overshadowing the societal value of good care. The depoliticized cost-efficiency measures, written as neutral and universal guidelines, “reproduces hierarchies of value through implementation” (Tate 2020: 85). The

value of care has shifted towards its financial value, undermining the societal value, through decades of emphasis on cost-efficiency.

Structuring care along the lines of cost-efficiency, has fragmented care practices and its organization and let to a decay in relational space essential to care performances. Lack of time and increase in administrative tasks as a consequence of fragmentation, infringe the relational space, causing careworkers to be unable to give the care they want or are trained to give. Consequently, stressful working conditions and lack of compensation for this, are at the roots of a cyclical cycle of lack of staff. It has left careworkers feeling undermined and underappreciated by their government.

Recent Developments

After the fieldwork period, there have been several developments concerning the piercing problems in the healthcare sector. Various groups of careworkers grew louder in their protests and started negotiations with the government through labour unions. Several changes have been implemented such as a raise in salary for nurses[11], prioritization of internal employees over the external self-employed[12] in work schedules and a new law "Wet Zeggenschap Zorg" that allows care professionals to have a say in policies when this is in the interest of delivering good quality care[13]. Yet, we should not cheer too quickly. Careworkers and their rights are spread over separated laws and labour unions, causing larger and louder groups such as hospital staff to get a 15% salary raise in the next two years, while careworkers in elderly are overlooked and seriously struggle financially in current times of inflation[14]. We should take a critical look at these developments, as they tend to serve as a mere band-aid rather than tackling the systematic root cause behind the haemorrhage.

[11] https://www.hrpraktijk.nl/topics/arbeidsvoorwaarden/nieuws/cao-akkoord-zorgpersoneel-onder-meer-15-procent-loonsverhoging-en

[12] https://nos.nl/artikel/2479837-cao-akkoord-voor-zorgpersoneel-vaste-medewerker-krijgt-voorrang-in-rooster

[13] https://www.venvn.nl/nieuws/video-wet-zeggenschap-in-de-zorg-een-feit/

[14] https://www.ad.nl/gezond/zorgmedewerkers-redden-het-niet-meer-met-salaris-ik-eet-veel-bij-mijn-ouders~a0aaa3b2/

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Appendixes

Participant Information Sheet

Beste lezer,

U ontvangt deze brief als deelnemer aan het onderzoek '*Werken in de ouderenzorg: de impact van bezuinigingen op zorgpersoneel*'. In deze brief staat een korte samenvatting over het onderzoek en enkele regelementen omtrent de publicatie.

Een belangrijk onderdeel van dit onderzoek, is dat het onderwerp wordt aangekaart en benaderd vanuit het perspectief van het zorgpersoneel. Hiermee doel ik niet alléén op de mensen die momenteel actief aan het bed staat, maar ook mensen die in het verleden in de sector hebben gewerkt. Juist de redenen voor bijvoorbeeld een 'carrièreswitch', hetzij naar een volledig andere sector, of een andere functie binnen dezelfde sector, vormen waardevolle informatie.

In dit onderzoek focussen we op de ontwikkelingen in de (ouderen)zorg. We nemen hierbij een grof tijdspan van ongeveer 1980 tot en met nu. In het onderzoek wordt er gekeken hoe de (ouderen)zorg in Nederland is georganiseerd en verandert. Hoe de dagelijkse zorg praktijken en handelingen eruit zien en hoe deze zich door de jaren heen hebben ontwikkelt. Er wordt gekeken naar hoe de problemen zoals hoge werkdruk, gebrek aan personeel en overbodig administratief werk, op de werkvloer werden en worden ervaren en wat de achterliggende oorzaken hiervan zijn. Een belangrijk punt in deze tijdlijn is de invoering van de marktwerking in het Nederlandse zorgstelsel in 2006, de economische crisis van 2008 en de nasleep hiervan die tot veel bezuinigingen leidde.

Dit onderzoek is onderdeel van de Master *Culturele Antropologie & Ontwikkelingssociologie: Visuele Etnografie*. Een hele mond vol. Met 'culturele antropologie en ontwikkelingssociologie' bestudeerd men culturele diversiteit en ongelijkheid over de hele wereld. Dit kan bij een kleine gemeenschap in de Amazone, zoals het stereotype beeld van antropologie ons vertelt, maar ook, zoals tegenwoordig veel meer voorkomt, binnen ons eigen land, cultuur en maatschappij. 'Etnografie' of 'etnografisch onderzoek' omvat het onderzoek doen naar de gewoontes en denkbeelden binnen zo'n cultuur of maatschappij. Het 'visuele' aspect wat hierbij komt kijken, verwijst naar het inzetten van beelden om zo tot aanvullende inzichten te komen. Beeld en geluid heeft namelijk een andere impact op ons dan geschreven of verbale tekst. Hieronder valt ook een audio-visueel eindproduct, een documentaire van +/- 30 min, naast de geschreven scriptie.

In eerste instantie blijft dit onderzoek binnen de kaders van de Universiteit Leiden. Dit betekent dat het *uitsluitend* wordt gedeeld met de scriptiebegeleiders en medestudenten aan deze universiteit en dat het wordt opgeslagen in het 'Student Repository' voor verdere educatieve doeleinden. Mocht het zo zijn dat deze Master scriptie in de toekomst buiten de Universiteit Leiden wordt gepubliceerd, dan zal daarvoor eerst uw toestemming worden gevraagd. Belangrijk is om te weten dat het *nooit* om 'rauwe' data gaat, maar om het verwerkte eindproduct.

Wat kunt u verwachten
Het onderzoek bestaat voornamelijk uit individuele interviews en groepsgesprekken. Hierbij wordt waar passend ook audio-visueel materiaal, zoals foto's, video's en tekeningen, gebruik om bepaalde onderwerpen aan te snijden. Bijeenkomsten kunnen worden opgenomen (beeld en geluid) voor zowel analytische doeleinden, als voor de uiteindelijke documentaire. Hiervoor wordt *altijd*, zowel mondeling als schriftelijk, uw toestemming gevraagd. Voordat de officiële documentaire presentatie plaatsvindt, wordt u eerst uitgenodigd voor een 'proefpresentatie'. Hierbij zullen we de film bekijken met de andere deelnemers en heeft u de mogelijkheid feedback te geven voor eventuele aanpassingen. De datum voor de uiteindelijke documentaire 'Afstudeer Show' hoort u nog.

Informed Consent Form

Formulier Geïnformeerde Toestemming

Als onderdeel van het onderzoek '*Werken in de ouderenzorg: de impact van bezuinigingen op zorgpersoneel*' uitgevoerd door Dewi Wiggers, student aan de Universiteit van Leiden, worden er audio-opnames gemaakt als onderdeel van uw participatie aan dit onderzoek.

Dit onderzoek onderzoekt de effecten van kostenbesparende beleidsmaatregelen in de Nederlandse gezondheidszorg op het zorgpersoneel. Hiervoor worden video en audio-opnames gemaakt tijdens interviews en andere bijeenkomsten. Deze video en audio opnames worden gebruikt voor analytische doeleinden en/of het audio-visuele eindproduct. Audio-visueel materiaal wordt opgeslagen op externe harde schijven en zal niet worden gedeeld met derden. Audio-visueel materiaal is per definitie niet anoniem. De materialen zullen alleen voor dit onderzoek worden gebruikt en worden maximaal 5 jaar opgeslagen. Door middel van dit formulier geeft u toestemming om gebruik te maken van het audio-visuele materiaal, dat alleen door klasgenoten en begeleiders gezien wordt. Voor het uiteindelijke product, de documentaire, geeft u na de proefscreening aparte toestemming.

Ik heb dit formulier gelezen en geef hierbij mijn toestemming om de opnames te gebruiken zoals hierboven is aangegeven.

Naam: _____

Handtekening: _____

Datum: _____

Media Release Form

Media Release Form

Als onderdeel van het onderzoek 'Neoliberaal Beleid in de Nederlandse Ouderenzorg' uitgevoerd door Dewi Wiggers, student aan de Universiteit van Leiden, foto's, geluidsopnames en video-opnames van u maken als onderdeel van uw participatie aan dit onderzoek.

> *Dit onderzoek onderzoekt de effecten van kostenbesparende beleidsmaatregelen in de ouderenzorg. Audio-visueel material wordt opgeslagen op externe harde schijven en zal niet worden gedeeld met derden. De materialen zullen alleen voor dit onderzoek worden gebruikt. Audio-visueel material is per definitie niet anoniem en kan dit dus ook niet garanderen. Er zal een 'trial screening' worden georganiseerd, waarbij u kunt aangeven wel of niet akkoord te gaan met de audio-visuele content. Na uitlevering van de laatste versie, kan uw toestemming niet meer worden teruggetrokken.*

Gelieve per punt toestemming geven voor het gebruik van audio-visueel materiaal. Dit is volledig aan u. Wij zullen alleen de materialen gebruiken op de manieren waarop u toestemming gegeven heeft. Plaats alstublieft uw initialen op de lijnen wanneer u hier toestemming voor wil geven.

1. De opnamens mogen gebruikt worden voor analyse in het onderzoeksproject.

   Foto _____ Audio _____ Video _____

2. The records can be used for scientific publications.

   Foto _____ Audio _____ Video _____

4. The records can be shown at meetings of scientists interested in the study of anthropology.

   Foto _____ Audio _____ Video _____

5. The records can be shown in classrooms to students.

   Foto _____ Audio _____ Video _____

6. The records can be shown in public presentations to non-scientific groups.

   Foto _____ Audio _____ Video _____

7. The records can be used on internet, television and radio.

   Foto _____ Audio _____ Video _____

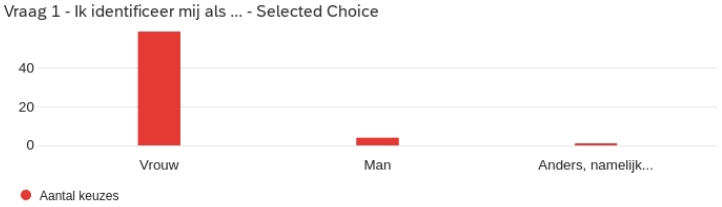
Ik heb dit formulier gelezen en geef hierbij mijn toestemming om de opnamens te gerbuiken zoals hierboven is aangegeven.

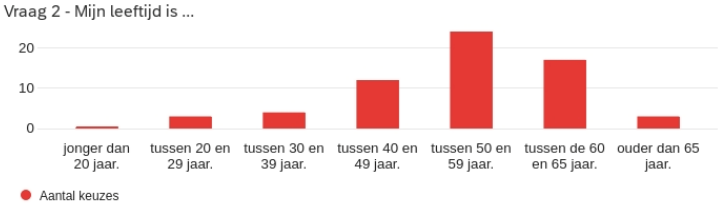
Naam _____ Handtekening _____Datum _____

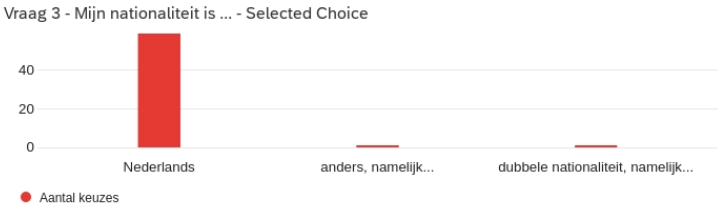
Discussion Points Focus Group

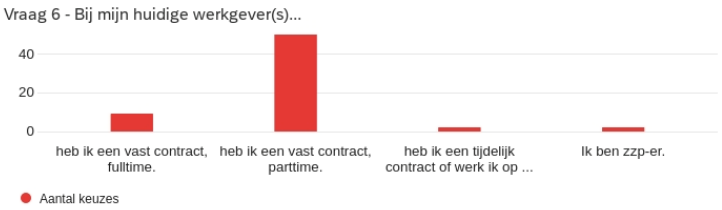
- Ik zou het niet erg vinden zelf in een verzorg-/verpleeghuis te eindigen.
- De Nederlandse overheid heeft de afgelopen decennia goede beslissingen gemaakt die de zorg/zorgpersoneel ondersteunen.
- Werken met een vast team is essentieel.
- De invoering van de marktwerking (2006) heeft een positief effect gehad op de werkvloer.
- Werken in de zorg is zwaar.
- Zorgplannen en andere administratieve registraties leiden tot betere zorg.
- Protocollen, regel- en wetgeving zitten soms in de weg van het leveren van goede zorg.
- Vrijwilligers en mantelzorg zijn de oplossing van het personeelstekort.
- Attitude samen schouders eronder verandert.
- Werken in de zorg is makkelijk te combineren met mijn privéleven (gezin/mantelzorg/hobby's).
- De overheid, zorgverzekeringen/zorgkantoren hebben vertrouwen in het kennen en kunnen van het zorgpersoneel.
- Het zorgpersoneel is te negatief over de huidige staat van de Nederlandse zorg.
- Er is een groot verschil tussen de papieren werkelijkheid en praktische realiteit.
- Ik kijk uit naar mijn pensioen.
- Goede zorg is efficiënte zorg.

Questionnaire Outcomes





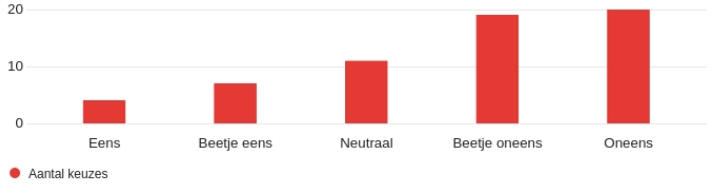




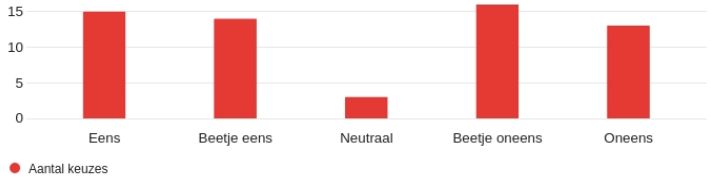
Vraag 9 - Hoe ervaart u ... op de werkvloer?

Veld	Min.	Max.	Gemiddelde	Standaardafwijking	Variantie	Antwoorden	Som
werkdruk	1.00	4.00	1.87	0.71	0.51	61	114.00
personeelstekort	1.00	4.00	1.79	0.79	0.63	61	109.00
waardering door collega's	1.00	5.00	2.66	0.74	0.55	61	162.00
administratieve taken	1.00	4.00	1.77	0.73	0.54	61	108.00
autonomie (naar eigen kennis en inzicht kunnen handelen)	2.00	5.00	2.85	0.85	0.72	61	174.00

Vraag 10_1 - Ik ben tevreden met mijn salaris.

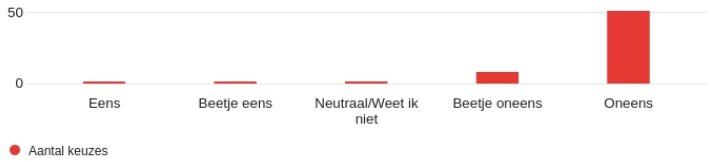


Vraag 11_1 - Ik voel me gehoord en gezien door mijn leidinggevenden/ management.



Vraag 12_1 - Vrijwilligers en mantelzorgers zijn een oplossing voor het personeelstekort in de zorg.

Vraag 13_1 - De Nederlandse overheid heeft de afgelopen decennia goede beslissingen gemaakt die de zorg en het zorgpersoneel ondersteunen.



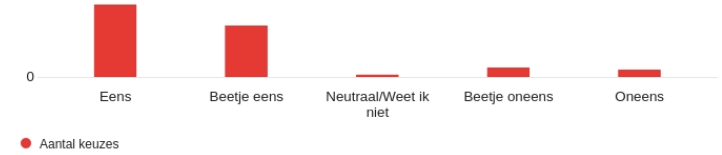
Vraag 14_1 - De invoering van de marktwerking in de zorg (2006) heeft een positief effect gehad op de werkvloer.

Vraag 15_1 - De zorg leent zich prima als verdienmodel.

Vraag 16_1 - De overheid, zorgverzekeringen/ zorgkantoren hebben vertrouwen in het kennen en kunnen van het zorgpersoneel.

Vraag 17_1 - Zorgplannen en andere administratieve rapportages leiden tot betere zorg.

Vraag 18_1 - Protocollen, regel- en wetgeving zitten soms in de weg van het leveren van goede zorg.

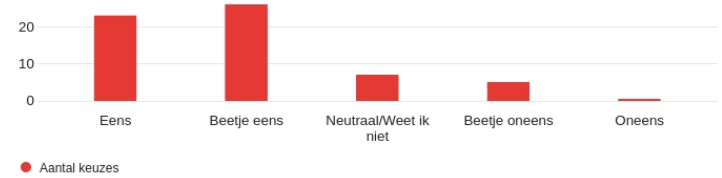


Vraag 19_1 - Er is een groot verschil tussen de papieren werkelijkheid (zorgplannen, -doelen en rapportages) en de praktische realiteit (dagelijkse gang van zaken).

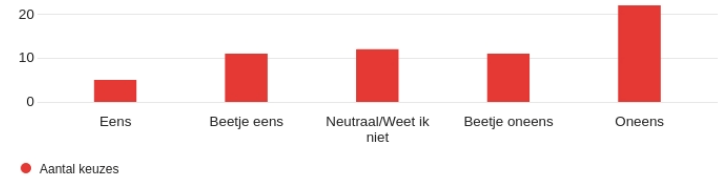
Vraag 20_1 - Werken in de zorg is makkelijk te combineren met mijn privé leven (gezin/mantelzorg/persoonlijke omstandigheden).

Vraag 21_1 - Ik voel mij fysiek belast na een lange werkdag.

Vraag 21_2 - Ik voel mij mentaal/emotioneel belast na een lange werkdag.

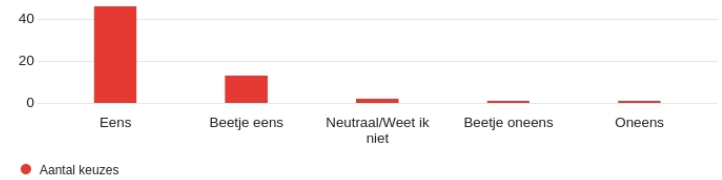


Vraag 22_1 - Het zorgpersoneel is te negatief over de huidige staat van de Nederlandse zorg.



Vraag 23_1 - Werken met een vast team werkt prettiger dan met steeds wisselende collega's.

Vraag 24_1 - Het geven van zorg is een intieme bezigheid.



Vraag 25_1 - Werken in de zorg is zwaar.

Vraag 26_1 - Goede zorg is efficiënte zorg.