Graduate School of Development Studies

CHANGING SOCIAL ARRANGEMENT FOR ELDERLY CARE IN THE NETHERLANDS:
Home Care and its Implications on Social Justice

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Anjani Francisco Abella
(Philippines)

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Members of the examining committee:

Dr Thanh-Dam Truong
Dr Rachel Kurian

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Inquiries:

Postal address:	Institute of Social Studies P.O. Box 29776 2502 LT The Hague The Netherlands
Location:	Kortenaerkade 12 2518 AX The Hague The Netherlands
Telephone:	+31 70 426 0460
Fax:	+31 70 426 0799

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LIST OF ACRONYMS

EEC	European Economic Cooperation
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
PBG	Personal Budgets or Individualized Budgets
SBP	Stability Growth Pact

Chapter no. 1
INTRODUCTION

1.1 Statement of the Research Problem

(S)ociety... is a symbolic construct composed of ideas, meanings and language which is all the time changing through human action and imposing constraints and possibilities on human actors themselves (Parton, 2003: 11). Subject to historical, social and cultural changes, the terms that define society, our belief systems, our actions, norm and values, and our practises are thus considered non-static and in a permanent state of flux. Departing from this conception of society, it then follows that inequalities, vulnerabilities and the status quo are all social constructs -- they are not natural, nor are they conceived of objectively. They can be challenged and they can be changed. As Roy (2001: 117) contends, 'these instances demonstrate how the boundaries between public and private shift with chameleon dexterity and how such shifts shape the allocation of needs, rights, resources, claims and responsibilities.'

The welfare state is an historical institution that was given rise to by the political process of nation-state rebuilding and reconstruction after the first two world wars. It is an institution that obligates the state to 'guarantee the welfare (that is something more than sheer survival; survival with dignity) of all its subjects' (Bauman, 1998: 45) or the 'well-being of their citizens' (Goodin et. al., 1999: 21). Considered 'an irreversible structure, the abolition of which would require nothing else than the abolition of political democracy' (Offe, 1981 in (Bauman, 1998: 47)) -- since the economic shocks linked to the two oil crises of the 1970s and the ideological ascendancy of neoliberalism (Mkandawire, 2001: 11), the sustainability of the welfare state has been put under extreme pressures and threat.

The reasons behind these policy shifts are complex and involve a convergence of several observable forces such as a rapidly ageing population (Biggs, 2001; Brie, 2004; Powell and Edwards, 2001); higher participation rates of women in the labour markets (Fraser, 1997; Razavi and Hassim, 2006); a shift in the mode of production from 'industrial manufacturing society to knowledge society' (Fraser, 2003: 1); and restrictions on budget for the social sector due to macro-economic reforms (Kurian, 2003: 4; Mkandawire, 2001: 11). The intention is to 'wisely' effect cuts on social spending and at the same time ensure that certain levels of social care are retained -- for, linked to Offe's earlier statement, a total abolishment of the welfare state would result to political suicide and chaos. Hence, set against the backdrop of a shrinking human and resource base for social care, it was necessary for public policy making to put to test its creativity -- to develop alternative solutions capable of rescuing social provisioning for care from imploding.

Focussing on restructuring elderly care, realizing that purely economistic solutions were no longer capable of meeting the goals of states, Bobbit (2002 in (Brie, 2004: 51)) observes that 'since the 1990s, the politics of cuts (has been) combined with systemic restructuring... (which now includes giving) primacy to individual self-provisioning.' Coined by Jordan (1998) as the 'new orthodoxy of welfare state restructuring,' he suggests that 'a central feature of the new orthodoxy is the idea that rights must be balanced by obligations.' All these are manifest in the case of Western Europe, where the process of restructuring social care for the elderly is fundamentally guided by norms of participation and solidarity.

Translated into policy, attempts are being made toward reconfiguring the meanings and practise of citizenship which follow two distinct but mutually reinforcing tracks:

1. A sharing out of responsibilities to elderly care which demands for active participation in the management and provisioning of care amongst family and community members. Otherwise referred to in this paper as 'informal care' or *mantelzorg,* in the context of the Netherlands, informal care was institutionalized in the policy document passed by the Tweede Kamer der Staten Generaal (Risseeuw in Truong et. al., 2006: 129) in 1994. It stipulates that the care needs of the elderly are to be supplied first and foremost by members of the family or community, which will only be supported through state assistance when proven that the care needs of the elderly cannot be supplied by his/her social networks; and
2. A re-conceptualization of old age and the ageing process which signifies a departure from traditional conceptions of old age conceived under the framework of the disengagement theory[1]. In concrete terms, this points out to the implementation of positive ageing (Biggs, 2001; Hantrais, 2000; Powell and Edwards, 2002; Sevenhuijsen, 1998) which incorporates the 'vocabulary of the market consumer' within its 'framework' (Calasanti, Slevin and King, 2006; Knijn in Harrington Meyer, 2000).

1.2 Research Focus and Justification

This paper explores the discursive shifts apparent in the process of restructuring policy on elderly care, focussing on home care as one type of arrangement and what these shifts ethically imply. The significance of locating the study in home care is explained by several observable factors:

1. it is the policy priority in the arrangement of social care for elderly in the Netherlands (Risseeuw, 2006: 129);
2. owing to its location, it is the arrangement that commands the active participation of all three direct subjects of elderly care (formal caregiver, informal caregiver and care receiver); and
3. it involves the crossing of the boundaries between the public and the private where allocation of resources and the social arrangements in (and experiences of) home care are determined at the public/political sphere, and operationalized in the 'unregulated sphere' of the private.

The study shows how the new orthodoxy of the welfare state -- understood as manifest in the introduction of new meanings and practises of citizenship or (referred to in this study as participatory citizenship) -- alters classical principles of welfare. In surfacing existing insecurities and vulnerabilities that emerge from the introduction of participatory citizenship, the study asserts for the need to exercise prudence in policy and decision making in the restructuring process. It is approached with a hypothesis that linked to the centuries-long marginalization and selective incorporation of the issue of care in the public sphere, the introduction of

[1] The disengagement theory was developed by Cummings and Henry in 1961. According to this perspective, the ageing process is regarded as a 'biological part of the life course oriented towards a mutual separation between the individual and society' (Estes, 2001: 25).

participatory citizenship is a 'double-edged process laden with both risks and possibilities.'[2]

In seeking to offer insights toward expanding the welfare of the subjects of elderly care amidst the pressures of restructuring and its new orthodoxy, the study borrows from the work of some feminist care ethicists (Sevenhuijsen, 1998; Tronto, 1994; Truong, 2006) and offers a suggestion where individuals are conceived in their relational selves as a departure point, rather than individual autonomous blocks. The study argues that in doing so, not only are we able to enrich the social meanings of care in the restructuring process, as well, through a relational lens, we also begin to question the logic and notion of efficiency and preference as state-constructed 'roadmaps' established as capable of providing a dignified life to all.

1.3 Research Questions

Concretely, this paper pursues the following research questions:

1. How do the main characteristics of participatory citizenship reconfigure the arrangement of elderly care?
2. In what ways does participatory citizenship impact on the social meanings of elderly care within the modality of home care (*thuiszorg*)?
3. What are the implications of the operationalization of participatory citizenship on conceptions of social justice?

1.4 Methodology

The paper seeks to make a general contribution towards enriching and enlarging the changing discourse on care in the context of welfare state restructuring. Its purpose is to question the norms and values of policy planning in the Netherlands, as well as emerge a range of examples that reflect the continuity or discontinuity between policy rhetoric and the lived realities in elderly care. The study contributes to 'the constant questioning of the ideal of the public, not to undermine its utility, rather, to strengthen the everyday idea of the public' (Rubin, 1975 in (Roy, 2001: 122)). In so doing, it applies Roy's (2001) approach to interrogating policy planning framed by two strands of analysis:

1. historically, socially and culturally situating the planners and planning machineries; and
2. questioning the lived realities and experiences 'of the subject positions that constitute the subjects of planning' (Roy, Ibid) facilitated by narrative approaches.

The findings and analysis of the study is supported by secondary and primary sources. Among the secondary sources helpful to this study include published and electronic scholarly articles and books; policy documents; and fact-finding reports on health care and ageing. Sources of primary data were largely obtained through the conduct of in-depth interviews (11) and participant observation (1) obtained from a mix of informal and formal care givers and receivers who were randomly

[2] This phrase is borrowed from Fraser who uses it to describe globalization and its impacts on our lives (See Fraser, 2003: 3).

invited through the network of the study's translaters. It is important to clarify that all informants to the study are female except for one elderly care receiver.[3]

A total of six elderly care receivers were formally interviewed. Of the six, one is male and three of the females live in a private 'senior housing' (woongemenschap). The age range of this group of informants falls between their mid 70s to late 80s (See Table 1). Significantly, I was also very fortunate to have had the chance to conduct a mix of intensive interviews and participant observation in the home of one female elderly care receiver, referred to in this study as Ms A1. The case of Ms A1 is a special one as, of all the six respondents, my engagement with her experience of home care was enriched by the active participation of her daughter (informal care giver), referred to here as Ms A2 and her formal care giver (Ms A3) in the process. All three gave interesting and differentiated accounts on the social arrangement of elderly care.

TABLE 1
Typology of Informants: Elderly Care Receivers

Age Range	Number of Informants	Gender	Living Arrangement	Language used during the Interview
76 – 80	2	F	woongemenschap	Dutch
80 – 85	1 (deceased)	F	'ancestral home'	Dutch
86 – 90	3	2 F; 1 M	1F: woongemenschap 1F & 1M: 'ancestral home'	2 F: Dutch; 1 M: English

Source: Informants, 2007.

Three informal female care givers were formally interviewed for purposes of this research. Of the three, two are daughters who render and have rendered care service to a living parent. The other respondent provides informal care to her spouse.

[3] While attempts were made to strike a gendered balance amongst the care receivers at least, in the course of research, I was informed by a home care personnel who linked me up with its home care patients that some problems were encountered in inviting male care receivers for the following reasons: a) women tend to outlive men; and b) women receiving home care in the said institution seem to be stronger and more 'lucid' compared to men.

TABLE 2
Typology of Informants: Informal Care Givers

Age	Gender	Participation in 'productive, labour force'[4]	Language used during the Interview
Mid 40s	F	Part-time	English
Late 50s	F	Part-time	English
Early 80s	F	Housewife	Dutch

Source: Informants, 2007.

Finally, two formal care givers were interviewed, one of whom was involved in the management of Ms A1's home care. Both women are in their mid-40s and have been working in their respective home care organizations for at least 7 years.

1.5 Scope

Changes within the social arrangement of elderly care takes place against the backdrop of the complex realities and interconnections of globalization, transnationalization and an ageing population. Further, the actual experiences of the direct subjects of elderly care only permit a selection of specific aspects regarding the current arrangement of elderly care in home care[5]. Finally, the study emphasizes the messiness of our social realities and goes by the words of Roy (2001: 120-2) who emphasizes that 'there are no quick and ready solutions to these dilemmas, but (in recognizing) these issues as dilemmas... the ideal is served not by idealization but rather through interrogation.' Therefore, owing to the limits posed by the macro and micro-environments, the findings in this study cannot be generalized, nor does it intend to generate policy solutions. It is however hoped that this study is able to open up new avenues in the process of decision and policy making in restructuring elderly care. It intends to elevate an array of debatable issues emerging from the changing social arrangement of elderly care which hopes to contribute to efforts of expanding the welfare of subjects of elderly care in the process of restructuring.

1.6 Structure of the Paper

The paper is structured in five chapters. The first chapter introduces the research by clarifying its orientation, highlighting what it methodologically sets out to do, as well as emphasizing its scope. The second chapter elaborates on the boundaries of care in the restructuring process and establishes the conceptual and analytical approach that will be used in the study. The third chapter applies the first strand of

[4] Information on the respondents' participation in the labour market is included to clarify that the study is unable to provide insights on how the current social arrangement of elderly care impacts on individuals with 'full time jobs.'

[5] This is largely in part owing to the fact that restructuring social care in the Netherlands is still ever-evolving where some policies have just been introduced (i.e. Social Support Act/WMO and Health Insurance Act of 2006), while others are merely policy briefs intended to guide policies on elderly care in the future (Policy for older persons in the perspective of an ageing population, 2006).

Roy's analysis by interrogating the norms and values that shape public policy making in the Netherlands and showing how these impact on caring arrangements and the identities of some subjects of care. The fourth chapter brings in the narratives of some subjects of care to elucidate on-the-ground issues that have yet to be dealt with by the state in policy formulation for elderly care. In the final chapter, I offer the general conclusions reached by the study.

Chapter no. 2
THE BOUNDARIES OF CARE IN RESTRUCTURING ELDERLY CARE: KEY ANALYTICAL ISSUES

This chapter establishes the importance of enlarging the social meanings of care in the process of restructuring social care for the elderly. The first part shows how the issue of care is treated in the public sphere and explains the need to deepen interrogation of the public sphere often taken as fixed and static. The second section briefly discusses that changes taking place in the public sphere primarily facilitated by the rise of globalization. In the third section, I will define what I see as two organizing principles of society and discern how these principles influence the state's interpretation and implementation of participatory citizenship within the framework of restructuring. In the fourth section, we then move on to examine how the introduction of participatory citizenship impact on the welfare of subjects of care and in meanings of social justice that encapsulate the importance and notion of the welfare state. In this section, we use Fraser's critique on the course being taken by today's restructuring process and briefly engage with her alternative theory of justice. Finally, we move on to discuss the political value of an ethic of care in the restructuring process and how the application of a relational lens to inform policy making enlarges welfare, and as such, the scope of social justice.

2.1 Power and Privilege in the Chameleon Dexterity of the Public-Private Divide

The public realm of policy making and planning is understood in this study as the site where ideas of care are validated, negotiated and implemented. Formerly understood as 'universal, rationale and objective,' the idea of the public is, as Roy (2001: 116) contends, 'fixed through knowledge/power relations' where while 'perfectly elastic, its flexibility (is limited) in keeping with political imperatives'. Truong (2007) adds, 'the impartiality of the public is fictitious,' and in the specific discussion of restructuring elderly care, Razavi (2007: 1-2) argues that understanding 'how society addresses care has substantive social significance (to discern) structures of power and inequality' (Razavi, 2007: 1-2).

'Feminist theorists argue that the idea of the public can only be understood in the context of a public-private dichotomy that feminizes and thereby depoliticizes the realm of the private' (Landes, 1998 in (Roy, 2001: 110). Feminists and a number of political analysts alike link the creation of this divide to the liberal tradition and principles of democracy. In its 'historic attempt to define a private sphere independent of the state that frees civil society... from political interference' (Held, 1983: 3), the writings of Hobbes and other liberal thinkers that succeeded him laid the ground for the normative and ethical bases of the existence and limits of the powers of the modern state.

In this light, social justice and care are discursively constructed in binary opposition to each other (Koggel, 1999; Sevenhuijsen, 1998; Tronto, 1994). Where classical meaning of social justice (redistribution) is understood as the domain of the state machinery; care-giving and receiving are understood as deeply personalized and context-specific activities and relationships within the private sphere which is no business of the state. It suggests that in as long as all citizens are guaranteed access to minimum universal care arrangements, then a 'minimum standard of dignified living' is achieved.

While it is crystal clear that the boundaries of the public and the private are not fixed, are ever-evolving and are social constructs, the incorporation of the issue of care in the public sphere -- since the creation of the welfare state -- continues to stubbornly deny and invisibilize some elements of care (i.e. quality care and caring relations). These elements are often sidelined, are devalued as a private matter, constructed as a question of ethics and morality, or a woman's issue among others (Tronto, 1994). Most often than not, these elements of care are rationalized by public policy circles as highly personalized and individualized issues incapable of creating policies based on universal care needs -- as if the process of arriving at its conception of universality is 'objectively discerned.' As Sevenhuijsen (1998: 138) explains, '...needs are the object of both negotiation and contestation, and thus of power struggles about who gets what.'

Owing to the universalizing power wielded by the state, in attempts of securing and enlarging the welfare of individuals in the process of restructuring, reconstituting the parameters of the public is therefore a key challenge. Asserts Roy (2001: 110):

> In the case of planning, the 'public' is a particularly powerful keyword precisely because it is commonplace, so integral to the vocabulary that the contours of its meanings are rarely visited, much less questioned. It is this matter-of-factness, this quality of being prosaic and obvious, that makes the investigation of the 'public' an imperative.

2.2 Situating Policy and Discursive Changes in Elderly Care

Various authors suggest that since the creation of the welfare state across Western Europe, economic growth and regeneration have always been top priority of its successive governments. Whether it was for purposes of national reconstruction which took on a 'basic needs and equity-with-growth strategy' approach during the post-war period; or restructuring (elderly care) in the latter part of the 1970s – social policy (the issue of care) has always been viewed as 'secondary' to economic growth (Atkinson, 1999 in Mkandawire, 2001; Hantrais, 2000) and a safety net (Bauman, 1998).

While policy prioritization over economic growth has not changed since the creation of the welfare state, what is important to note is that fundamental physical and discursive changes have taken place in the economic, social and political spheres of society linked to globalization. Borrowing from Bourdieu and Foucault's political writings (in Biggs, 2001: 304-5), globalization is viewed as creating the dominant 'constellation of ideas' which rearranges and 'consecrates' existing systems and structures of society. Fraser (2003: 1) categorizes the forces of globalization based on four epochal shifts. These are:

1. 'Shifts in... the composition of the labour force (increased participation of women in paid labour force), and the work/life balance (rethinking normative construction of family wage and organization of social protection formerly organized around a patriarchal breadwinner model);
2. Shift from industrial, manufacturing society to knowledge society;
3. Shift in traditional understanding of sovereignty of a nation state moving towards a globalized order where free movement of capital undercut national state steering capacities; and
4. The explosion of identity-based struggles and the 'increased salience of culture in the emerging order'.

All four epochal shifts provide a useful framework that rationalizes and shapes the policies discerned in the development and reinforcement of home care as a government priority in organizing social health care.

2.3 A Market and Middle-Age Bias In Shaping the Identities and Responsibilities of Citizens

At the risk of oversimplification, a change in the mode of production; technological advancements made in the domain of information, communication and computer technologies; regional integration towards policy and decision making; and the increased strength of democratization struggles open up avenues for the recognition and participation of previously marginalized identities in both the private and the public spheres -- this including women and the elderly, as well as 'half-hearted attempts' to also include men in the realm of social care. This framework of inclusion is manifest in the introduction of participatory citizenship where as responsible partners in society, individuals (women and men, the middle-aged and the elderly) are provided with the structural opportunities to balance their participation in the productive and reproductive spheres. The terms of inclusion and participation are however highly contentious sites of debate where the 'emancipation' of women, men and the elderly have also been accompanied by critiques that perceived as token efforts and reinforcing existing hierarchies.

To illustrate, positive ageing is celebrated by some social gerontologists and postmodernists for 'constituting a sharp break with previous policies toward older people... in so far as it seems to have learned many of the lessons preached against ageism, structured dependency and passivity in later life' (Biggs, 2001: 308) -- however, it is also critiqued for its market and middle-age bias. Biased to the corrective mechanism of the market, Knijn (in Harrington Meyer, 2001) asserts that today's process of reorienting the citizenship status of the elderly is accompanied with the introduction of a market consumer in the elderly's identity. In this light, 'normal citizens are... first and foremost constructed as individual participants in the labour market... (who) is supposed to translate his/her needs for care in terms of market-oriented behaviour, thus conceiving him/herself as a care consumer in a market of supply and demand (Sevenhuijsen, 1997: 57).

Further, critical of the organizing feature of the market, feminist social gerontologists also point out to a middle-age bias (Calasanti, Slevin and King, 2006) where the identity of the elderly is being reconfigured based on the notion of a homogenous group that is able-bodied, mentally alert, mobile, and capable of protecting themselves and asserting their own independence. Observes Calasanti et. al. (2006), Biggs (2001) and Powell and Edwards (2001), policies informed by today's notion of 'positive ageing' treads the dangerous path of homogenizing the identities and positions of the elderly. In doing so, the special needs of some elderly individuals are invisibilized. Observes Biggs (2001):

> Like the postmodern reshaping of aging as a matter of midlifestyles (Featherstone & Hepworth, 1982), the policy narrative (of productive ageing) solves the problem of ageing by assuming that older people are the same as everyone else... However, it may be inaccurate to characterize older people as having the same abilities (to do the same jobs as younger adults) and needs (without special requirements because of disabilities associated with age) as other sections of the population.

2.4 Participatory Citizenship: An Expansion or a Contraction of the Social Justice Project of the Welfare State

While authors like Bobbit (in Brie, 2004: 51) express that the introduction of frameworks of inclusion (participatory citizenship) reflect a fundamental change in the process of restructuring, several authors note that it is also one that enlarges conceptions of social justice. No longer limited to purely distributive frameworks linked to the 'classical social needs '(Robeyns, 2006: 2), and 'equity with growth strategies' (Mkandawire, 2001: 1) typical of the Rawlsian framework of social justice -- the incorporation of previously marginalized identities and subject positions is considered by Fraser (2003: 3) as 'a welcome advance.' In theory and practise, the Rawlsian framework is critiqued as incomplete owing to its inadequacy towards redressing harms 'rooted not in the political economy, but in institutionalized value hierarchies' (Ibid). While other analysts observe that the Rawlsian framework's limited conception of the individual is de-linked from a social or political perspective and as such, 'cannot readily be applied to real world political problems' (Collins, 2007: 3).

In as long as distributive frameworks of social justice are not compromised by recognition frameworks:

> The turn to recognition represents a broadening of political contestation and a new understanding of social justice... no longer restricted to the axis of class, contestation now encompasses other axes of subordination, including gender, 'race', ethnicity, sexuality, religious, and nationality... (it) represents a welcome advance over reductive economistic paradigms that had difficulty conceptualizing harms rooted, not in political economy, but in institutionalized value hierarchies (Fraser, 2003: 3).

However, an examination of the current social arrangement of elderly care in home care, shaped by the inclusive framework of participatory citizenship in the restructuring process indicates otherwise. Drawn from the Eurofamcare Report (Visser-Janssen and Knipscheer, 2004), the incessant cuts made towards health care budgets have resulted to the unfair transfer of a range of care activities formerly located in the formal sphere towards informal carers (*mantelzorg*); between 150,000 – 200,000 informal caregivers are overburdened, the intensity of which varies depending on the numbers of informal caregivers involved; and since the institutionalization of informal care (*mantelzorg*), stricter regulations toward the approval of home care requests is discerned -- in this light, 'formal care is indicated only if the need for care is very high and/or informal carers are no longer able to perform the required care activities (Ibid: 17).'

On the other hand, while it is too early to discern the actual impacts of positive ageing given its 'infancy' in the scheme of participatory citizenship, the forward looking policy document entitled *Policy for older persons in the perspective of an ageing population* (2006) also strongly reveals the retreating role of the state towards the management and financing of social care. In this light, the policy brief suggests that policies for the future elderly will be designed to encourage greater responsibility from its citizenry whose ageing is anyway inevitable and who, compared to the elderly of today, have more life chances (higher incomes; better educated) thanks to the globalization and technological advancements made towards the end of the 20th century.

The retreating role of the state discerned in the examples I mentioned above is coined by Fraser as the *problem of displacement* -- where recognition of previously marginalized groups and incorporating 'them' into the social justice fabric of the

welfare state creates a vacuum in state responsibilities toward redistribution. In her earlier work, Fraser (2003: 5) claims that in order to overcome the problem of displacement, 'it is necessary to submit the dimensions of distribution and cognition to an overarching norm of participatory parity (which) supplies a single normative standard for assessing both the economic structure and the status order.' Her conception of participatory parity is explained as follows:

> According to this principle, justice requires social arrangements that permit all (adult) member of society to interact with one another as peers. For participatory parity to be possible, at least two conditions must be satisfied. First, the distribution of material resources must be such as to ensure participants' independence and 'voice'... and the second condition... requires that institutionalized patterns of cultural value express equal respect for all participants and ensure equal opportunity for achieving social esteem (Fraser, Ibid: 4-5).

While I certainly agree with Fraser's conception of the problem of displacement, unfortunately, by virtue of the links between her conception of participatory parity and a liberal framework to democracy, her social justice framework still fails to redress insecurities and vulnerabilities that stem from processes and relationships. This is largely due to her making use of the values of independence, voice and social esteem as the 'primary indicators' of her conception of participatory parity. All built on the conception of an autonomous individual, Fraser's dimensions of social justice assessed through the normative framework of participatory parity, assumes that the focal objective is 'participation' or 'inclusion' in a 'democratized public sphere.'

On the one hand that a number of political analysts/theorists and social scientists have argued that the very norms and values that shape the practise of 'participation,' 'inclusion' and 'democratization' need to be interrogated -- in the specific context of elderly care, the narratives used for the purpose of this study suggest that none of these aspects of citizenship are central to the elderly's conception of welfare to date. More than participation and inclusion in the public sphere, what needs to be reckoned with, as their narratives suggest (as well as other subjects of care), is for the restructuring process and frameworks of social justice to begin giving accord to caring relations and experiences toward shaping policies for elderly care. As the findings of this paper suggest, the continued practise of a narrow conception in the social meanings of care -- or what matters and are most valued by the subjects of elderly care -- does not only neglect what the subjects of care have to say about how they perceive welfare should be (a dignified life for all) -- but also preserves today's status quo and value hierarchies where the markets and productivity come first and foremost.

2.5 The Political Value of an Ethic of Care in Restructuring Elderly Care

By now it should be clear that the attempts of liberalism to create marked divisions between the public and the private in order to rescue the private from authoritarian rule or the coercion of the state (public) is, more than a failed project -- an imagined state of mind that is held together by the dominant 'constellation of ideas.' As Truong (2007) presents, 'in practice, the private is not untouched by law and policy (marriage law, age of consent...) and the public is not untouched by private concerns and discreet actions of interest groups.'

Further, participatory and inclusion frameworks are social constructs and are heavily shaped by interest groups. Formulating care policies on the basis of participatory and inclusion frameworks are marred with too many problems and have great implications on subjects of care, as well, the overall democratization process. Constructed based on a liberal conception of the autonomous individual, as Young (1990: 98 (in Sevenhuijsen, 1998: 45-6)) very succinctly and powerfully puts it:

> The logic of identity expresses one construction of the meaning and operations of reason: an urge to think things together, to reduce them to unity. To give a rational account is to find the universal, the one principle, the law covering the phenomena to be accounted for...it tends to conceptualize entities in terms of substance rather than process or relation; substance is the self-same entity that underlies change, that can be identified, counted, measured.

Emerging the political value of an ethic of care is fundamentally the political project of feminist care ethicists. The ideology behind the construction of an ethic of care varies in two. One type links an ethic of care to the gendered roles and activities of women's morality, compassion and motherhood; while the other -- to which this research paper subscribes to -- views an ethic of care as a fundamental feature in our lives which is 'part of the fabric of society and integral to social development' (Daly, 2001 in Razavi, 2007: 1).

An ethic of care in this study is viewed as one that works toward providing welfare -- the dignified survival of all -- through a system of 'just caring' (Koggel, 1999: 4). A system of 'just caring,' asserts Koggel is one that departs from 'relationships rather than care (as) the focal point for theorizing about equality. We begin by moving away from thinking of care as an uncritical response to helping or taking care of others in personal relationships.' Put simply, a relational lens is used as the departure point towards constructing elderly care policies in the restructuring process. This is especially significant since any policy change towards home care -- an arrangement directly participated in by at least three individuals (the care receiver, the informal care giver and the formal care giver) -- is experienced as a chain reaction amongst all three. Hence, through the lens of an ethic of care, individuals are not seen in their 'separate, isolated shells,' rather in the light of their 'interdependence with other human beings' (Williams, 2003).

Chapter no. 3
SITUATING THE PLANNERS OF ELDERLY CARE IN THE NETHERLANDS

This chapter explores the restructuring process by historically, socially and culturally situating planners and planning machineries in the Netherlands. It starts with a section that discusses the social and political value (and pitfalls) of tolerance toward expanding welfare for all. This is followed by a section that maps out the contours of decision making processes within regional integration -- in particular the enlargement of the European Union -- to which reveals the primacy of macro-economic policies over social (care) policies is apparent. In the third section, we begin to be introduced to how the identity of elderly citizens is gradually being reconfigured by the market through the government's emphasis on elderly choice and preference behind the growth of home care. This is followed by the fourth chapter which outlines three policy innovations within home care that I view crucial towards consolidating the 'new' meanings of Dutch citizenship, demanding for and institutionalizing greater responsibilities from the individual care receiving and care giving citizen. In the final chapter, we are provided with a glimpse with regard to the future policies of elderly care which reveals how participatory citizenship -- the new orthodoxy of the restructuring process -- is being used more in its instrumental form to facilitate continued cost-cutting measures and the retreating role of the state from elderly care provisioning.

3.1 The Cultural and Political Context of Public Policy Planning in the Netherlands

The Netherlands is a country known the world over for its tolerant views on issues traditionally perceived as immoral. Among these include the legalization of marijuana, prostitution, euthanasia and same-sex partnerships. In the arena of policy making, grounded on a long historical tradition of (political) tolerance, the country is also known to have one of the more democratic systems and processes of public decision making. In the Dutch context, Schuyt (2004: 121-2) links the origins of political tolerance to the moral values promoted and subscribed to by the biblical humanists Erasmus and Castellio. Critical of the Dutch's indiscriminate adherence to and practise of orthodox religious doctrines during the 16th century, both advocated a humanist philosophy where 'moral values are properly founded on human empathy and scientific understanding' (Truong, 2007). From this period on, tolerance evolved as a key feature in Dutch society which was to dominate the political and socio-economic life of the country. Observes Kickert (1996: 89), 'accommodation, deliberation, compromise and consensus are key (features) in Dutch political culture and practise.'

The emergence of a 'European model of democracy -- corporatism -- in the 19th century' (Ibid: 88) provided the ideological framework to facilitate the transformation of the social value of tolerance to a political one. Kickert (Ibid) defines corporatism as 'a European model of democracy which emphasizes interests represented by small, fixed numbers of internally coherent and well-organized interest groups that are recognized by the state and have privileged or even monopolized access to the state'. This type of democracy, adds Therborn (1989), creates exclusive and specialized cleavages, shaping social institutions 'virtually in their own image and likeliness.' In doing so, it deeply entrenches the

influence of these small interest groups in society which was later on to be referred to in the Netherlands as -- the 'pillarization of Dutch society (Risseeuw in Truong et. al., 2006)'

More than a country-wide embrace of the humanist virtue of empathy, the emergence of corporatism suggests that the value of tolerance was used more in its instrumental form where various authors note that the rationale behind its creation was to 'counter the threat of labour revolt and rising socialism in the late 19th century.' Owing to the low levels of 'stateness' in the Netherlands during that time (Ferrera, 2003: 64), the government was left with no choice but to seek assistance from the already highly organized religious formations of Dutch society -- Protestantism and Catholicism and provide opportunities for the new political ideologies of Liberalism and Socialism to 'create their own exclusive and specialized cleavage.'

In this sense, we can easily rationalize that the emergence of corporatism was beneficial for the Dutch government as much as it was for the four pillars of society back then and now. In the same vein that it created the necessary mechanism to silence revolt in the 19th century, it also set the stage for the strengthened influence of the various pillars in public life.

As a social or political value, or as both, there is however two fundamental problems discerned in the practise of political tolerance in today's context. Drawing from Lijphart's (in Bakvis, 1984) work, the conduct of tolerance in policy making and the amazing feat of bringing together the competing interests of the pillarized structure of society was entirely, if not, largely dependent on the role of cross-pillar elites[6]. In addition to the centrality of the elite in Dutch public life and policy making, Risseeuw (2006) draws our attention to the ideological limits of the exercise of political tolerance in the pursuit of justice in welfare provisioning appropriate in today's historical context. In her more recent work on citizenship and gender, she emphatically argues how the traditional pillars are incapable of fully tackling new issues categorized as issues of the new social movements -- feminism, identity politics, and migration. As Risseeuw claims, these pillars are traditionally androcentric, very exclusive and 'anti-immigrant'[7]. In using Risseeuw's (2006) own words, 'If situated along the Amazon instead of the Rhine, the Dutch would no doubt have been applauded for their ability to retain their way of life and outlook, while surrounded by forces of change.'

While various Dutch politicians claim that the Netherlands is no longer a pillarized society, the influence of these pillars are manifest in public life (and decision making) where all four make up the country's major political groupings. Further, as an ideological principle of the Dutch welfare state,[8] corporatism implied that:

> ...public care service are only additional to the care the family can provide... and the welfare state delegates the responsibility for the provision of care services to private non-profit organizations, which in the

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[6] See Bakvis, 1984.

[7] See Risseeuw in Truong, Chhachhi and Wieringa, 2006)

[8] The Dutch welfare state is characterized by some scholars as home to a hybrid welfare regime. A hybrid welfare regime refers to a welfare structure that is organized by the combination or amalgamation of two or more ideological premises which inform the development, arrangement and provision of welfare services. In the Dutch case -- the principles of social democracy and corporatism are considered the major ideologies that inform the organization of the Dutch state (Risseeuw, 2006; Robeyns, 2006).

case of the Netherlands, originally were connected to different religious and political ideologies (Knijn in Harrington Meyer, 2000: 240).

3.2 Restructuring the Welfare State against the Backdrop of European Enlargement

3.2.1 The Centrality of Economic Policies in the European Union

Various scholars note that the European Union (EU) is historically a multilateral regional body whose rationale for coming together is largely pushed by visions of advancing economic cooperation. Its strong emphasis on advancing economic interests may be explained by the original intents of this formation, finding its roots in the establishment of the European Economic Community (EEC) of 1957. Now called the EU, it is a regional cooperation whose membership has expanded from six to twenty seven.

Then and now, debates on social policy in the EU emerge in view of advancing economic policies. Two dominant views prevail in the development of social policy. The first one generally conveys social policy as a 'residual category of safety nets' (Mkandawire, 2001: iii) which redress the 'social consequences that arise from the state's allegiance to macroeconomic policy (stability and growth)' (Atkinson, 1999; Mkandawire, 2001: 22).

The other view perceives social policy as a 'nuisance.' Perceived as getting in the way of labour and the markets, as Hantrais (2000: 2) observes, the discussion on the social dimension and care at the level of the EU, stem from European commitment to enlargement where 'any reference to the social dimension is found in the overriding principle that distortion of the rule of competition was to be avoided at all costs…'

In this light, the emergence of issues of elderly care do not exactly emerge out of a genuine concern for their plight and struggles which include among others, loneliness, depression, feelings of insecurity over loss of 'productivity' and 'self-sufficiency.' Rather, it is an issue that grows out of the 'disconcerting' demographic turn to an ageing population seen to distort principles of economic competition linked to productivity loss. While in the 1990's there emerged more consolidated efforts toward 'reconciling work and family life' (European Commission, 2003: Preface), at the heart of these debates within the EU is a concern over protecting economic policies. Any discussion beyond what is popularly termed as the work/life balance is 'largely confined to awareness raising, monitoring, reporting and sharing of experiences' (Hantrais, 2000: 162).

3.2.2 Institutionalizing the Convergence of Economic and Social Policies

The creation of the European Union in the signing of the Maastricht Treaty (formerly known as the Treaty on European Union) in February 7, 1992 marked the beginnings of a far more integrated approach to social and economic policies. Among the main features of the treaty was a specific agenda towards the adoption of a single European currency to boost economic performance and prosperity.

> The treaty defined a set of 'convergence criteria' that specified the conditions under which a member would qualify for participation in the common currency. Countries were required to have annual budget deficits not exceeding 3 percent of gross domestic product (GDP), public debt under 60 percent of GDP, inflation rates within 1.5 percent of the three

> lowest inflation rates in the EU, and exchange-rate stability (European Union, 2007).

The linkages between economic and social policy were further strengthened in the agreements arrived at during the Lisbon Summit (22-4 March 2000) and the Nice Summit (7-10 December 2000) which Salais (no date) marked a clear departure from the classical principles of the welfare state. Observes Salais (Ibid), at the turn of the new century, 'social policies in Europe must be viewed together as the apex of a triangle of mutually reinforcing policies: employment, social protection and the economic and budgetary policy.' Since the Lisbon Summit, explains Wichterich (2005: 13), it became more apparent than ever that '(t)he overall goal for (the restructuring process) is competitiveness of European economies and the single EU market in international trade and the world market.' In deep contrast to the analysis of Wichterich, in a speech presented by the Dutch Ministry of Foreign Affairs, growth and generating jobs were presented as instrumental to 'the true aim of the Lisbon Strategy (which) is to preserve and strengthen the European way of life, with its emphasis on prosperity, social cohesion and sustainability'. According to Dutch Ministry of Foreign Affairs, the European way of life -- 'good education, access to health care, dependable social programmes for the elderly, adequate welfare systems and a healthy environment' -- all need to be safeguarded.

Besides the fact that Europe is wrongly assumed to be or is misrepresented as a homogenous region, the Dutch Ministry also conveniently avoids a discussion on the rationale behind the adoption of the Stability Growth Pact (SGP) which I see is a crucial departure point towards revealing the centrality of macro-economic growth to the EU. The SGP was designed to create the necessary preconditions (as well as sanctions) for countries that seek to participate in or have already embraced the Euro as its currency. It is a 'political agreement that laid out the rules for the budgetary disciplining of the members states... designed to contribute to the overall climate of stability and financial prudence...' (EurActive.com, 2004). Linked to the sharp socio-economic differences amongst the member states, Fourcans (2000: 2) observes that there was a fear over:

> 'uncoordinated and divergent national fiscal policies would undermine monetary stability and generate imbalances in the real and financial sectors of the Community' (Delors, 1989) as well as create free-riding behaviours -- where some countries could implement too large a budget deficit that could lead to an increase in the interest rate for the monetary zone as a whole and/or a currency appreciation.

As Atkinson (1999 in Mkandawire, 2001: 22) explains, 'the first of these impediments is the persistence of economic policy making based on a leader/follower model where macroeconomic policy... is determined first and social policy is left to address the social consequences.' In an environment where the ideology of the market aggressively establishes itself as a fundamental organizing pillar of society, as a result, conceptions of justice are ideologically reformulated where 'the labour market becomes key to justice' (Jordan, 1998). In connection to this, the social arrangement for elderly care as a justice issue becomes re-oriented to catch signals from the market. Finally, citizenship rights and responsibilities are recast, instrumental towards ensuring the continued vibrance and economic competitiveness of the nation state and the EU.

3.3 Home Care vs Institutional Care

Towards the latter part of the 1970s but more concretely in the 1980s, state policy prioritization and promotion of home care was witnessed across Western Europe (Risseeuw in Truong, 2006: 128). The rationale behind this location shift is portrayed as the state's response to the intersecting forces of the market and demographic changes *and* a paradigm of choice by the elderly -- dissatisfied with the 'coercion and constraint associated with institutionalization' (Callahan 1981, Cetron 1986, Halamandaris 1986 in (Collopy et. al., 1990: 2)). According to these authors, the depleting budgets toward the financing of social care for the elderly linked to the state's fiscal disciplining of social expenditure are only partly to blame. In this light, they assert that the move to home care is also a response to the cries of the elderly and their families who found institutional care de-personalizing/de-humanizing, mechanical, and paternalistic -- which in turn result to the deteriorating quality of care, as well, the loss of autonomy and dignity of some elderly patients.

While agreeing in principle with the observations of the above-mentioned authors, how these facts are brought forth in the public is crucial. On the one hand that it is true that some elderly and their families prefer personalized home over institutional care, on the other, too much emphasis on this paradigm of choice creates an incomplete picture of the complex realities that pushed for the institutionalization of home care. In this light, policy rhetoric often puts emphasis on the paradigm of choice in rationalizing its policy shift to home care. Most often than not, elderly preference is importantly attributed as a fundamental reason behind the government's policy shift on the arrangement of social care for the elderly. Drawn from the *Fact Sheet on Senior Citizens in the Netherlands* (NIZW and NPOE; 2002: 5), research institutes connected to the Ministry of Health, Welfare and Sports assert that 'independent living and respect for personal lifestyles is also paramount to the older people themselves. Many senior citizens prefer to live at home as long as possible and, when necessary, to be supported by community care service'. In this sense, the government portrays itself as:

1. dynamic which seeks the innovation of care systems steered to a certain degree by the voices and participation of citizens;
2. gives primary concern towards the preference of the elderly; and
3. recognizes and respects the elderly as democratic subjects.

In doing so, it is able to create an image of a 'responsive government.' But, more fundamentally, it discourages a deepened interrogation of the social and political factors that buttress the inefficiencies of the bureaucracy and de-personalized professional/institutional care. It portrays bureaucratic inefficiency and de-personalized professional care as static and fixed -- as if they are not in themselves designed and constructed by human beings. Further, it constructs home care as the only social arrangement capable of meeting the personalized demands of care receivers and their families, reinforcing the dichotomy between the personalized and caring private and the universally just (but poorly equipped) public.

3.4 Reconstituting Dutch Citizenship in Home Care

Various authors note that compared to many Western European countries that began prioritizing home care in the 1980s, the Netherlands is a special case in that it was successful towards reducing budgets to home care several times while

budgets in other countries were rising[9] (Risseeuw in Truong, 2006: 129). Further, focal to this study, the policy shift to home care also served as the institutional springboard that facilitated the gradual re-configuration of citizenship status within caring arrangements which I deem, to date, have taken place in three phases. Before illuminating these three phases, it is first important to note what Hermans and den Exter (1998: 2) propose when examining the Dutch government's health care policy:

> The Dutch government's health care policy must be viewed against the background of the broader aims of the Dutch cabinet. The threefold objectives... are to reserve social security for the most needy of its citizens, to achieve cost reductions, and to create a new balance in the responsibilities shared by the citizen, State, business and social partners. It is assumed that market forces will assist in the accomplishment of this last objective.

The participation of members of family and community (in particular, women) towards providing care for the elderly has always been ever-present but significantly invisibilized in policy making circles. As noted earlier, owing to a policy shift in the labour market which encouraged the participation of women in the labour force, the invisible safety net of care in the 'unregulated private sphere' (Collopy et. al., 1990) eroded. Faced with the joint problems of a depleting monetary and gender-organized human resource base, in 1994, 'informal care' was recognized and institutionalized by public policy in the policy document passed by the Tweede Kamer der Staten Generaal. 'In 1994, private home care undertook four times as much care as government home care' (Risseeuw in Truong et. al., 2006: 129).

As one type of elderly care arrangement, home care is further subdivided into two types -- agency-directed and consumer-directed home care (Wiener et. al, 2003: vi). While agency-directed is the more active of the two, in the Dutch context, 'growth in consumer-directed home care (and the use of family caregivers) is discerned which is, in part, a frustrated response to the waiting lists for agency-provided care' (Ibid). In this section we will be concerned with the second type which will be referred to in here as the personal budget option or the PBG[10]. In here, the introduction of the PBG is considered the second phase that reconstructs the citizenship status of elderly care receivers.

The PBG is an arrangement that allows care receivers to compensate members of their family and community rendering care service (Integrated Care Systems, 2004: 2-3). It is, similar to the creation of the welfare state; the rise of corporatism; and the growth of home care, a 'double-edged process' -- which I will present here as a mechanism of control and that of emancipation. As a mechanism of control, the provisioning of PBG is a preferred arrangement for elderly care in the light of cost-cutting measures where the cash equivalent of an agency-directed arrangement is not completely turned over to a PBG beneficiary. Explains Wiener (2003: 31):

> The monetary amount of the personal budget for home and nursing services is determined by multiplying the number of hours needed of each of eight services times the national average payment rates for those services, then reducing the amount by 25% and an income related

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[9] Als see Kremer, 2000: 38; Tester, 1996; Goewie and Keune, 1996.

[10] Another term for PBG is individualized budgets which is used by Knijn in her contribution to Harrington Meyer's publication (2000: 232-48).

payment[11]. The 25 percent discount is supposed to account for the fact that independent providers do not have the overhead costs that agencies must incur.

On the other hand, as a mechanism of emancipation, the PBG allowed for the further recognition of family and community informal care providers through compensation. Equally as important, it gave the elderly care receiver the opportunity to take control of their health needs, which in turn reduced feelings of insecurity, dependency and humiliation over receiving 'informal care'[12].

Finally, focusing on the 'emancipation' of the elderly from the traditional dependence discourse, the introduction of the PBG laid the ground for a more consolidated strategy towards re-shaping the identity of the elderly. Liberal views of autonomy and free choice evolved as the new conception of elderly citizenship. The capacity for autonomy and free choice was further rationalized by evoking images of the 'far more advanced' capabilities of today's elderly evident in many state policy documents on old age and elderly care[13]. Better educated and relatively more prosperous compared to the elderly at the time the welfare state was created, the elderly of today are perceived more self confident and having a greater say in matters concerning their health and their welfare (Ministerie van Volksgezondheid, Welzijn en Sport, 2006: 12; NIZW/NPOE, 2005: 9). At the turn of the new century, the notion of 'self-care' was firmly put in place where a conception of the 'emancipated elderly free from the bonds of dependence' accompanied earlier moves to recast the health care system in the Netherlands from one that was supply driven to demand driven (Ministerie van Volksgezondheid, Welzijn en Sport, 2006).

3.5 A Glimpse into the Future Social Arrangement of Elderly Care

Within the scheme mentioned above, not only do the elderly become partners in the arrangement of social care along with the *mantelzorgs*, rather, at the turn of the new century, various policy briefs and documents indicate a growing trend towards evolving the 'potential' of positive ageing as the focal strategy of social cohesion in rescuing social provisioning for elderly care from its demise. In an environment faced with the tensions between a labour policy that promotes the participation of women (who were the former invisible and unrecognized providers of care) in the labour market for economic regeneration and the demands toward sustaining social provisioning for elderly care (Risseeuw in Truong et. al., 2006), the prioritization of positive ageing is considered a logical move by Eurofamcare (2004: 50). As the Eurofamcare (Ibid) report communicates:

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[11] 'The income-related copayment is based on two-year-old tax returns; assets are not take into account. The copayment rates are slightly higher for persons age 65 and older than for persons younger than age 65, which is probably equalized by the lower tax rates for older persons' (See footnote; Wiener in Wiener et. al, 2003: 40).

[12] Collopy et. al. 1990.

[13] Perhaps that most important and comprehensive policy document that underscores the 'educational achievements and heightened income levels of the elderly' may be found in the *Policy for older persons in the perspective of an ageing population* (Ministerie van Volksgezondheid, Welzijn en Sport, 2006). Also, see *Factsheet Senior Citizens in the Netherlands* (2002).

> In the national policy, the term 'own responsibility' is a very important and often mentioned word. The government is looking for cheaper or more affordable solutions for the increasing need for care. Reinforcement of informal care and voluntary care is a logical move.

The policy prioritization of positive ageing is evident in the forward-looking policy document *Policy for older persons in the perspective of an ageing population* (Ministerie van Volksgezondheid, Welzijn en Sport, 2006) which strongly hints that self-care will be given primacy towards the management of elderly care in the near future. The second line of defense will then be located in the good will of members of the family and the community. Finally, only when these two fronts fail at meeting the care demands and needs of elderly citizens will the state intervene. This type of arrangement is being proposed by the state to 'rescue social provisioning for elderly care' in the context of a depleting monetary and human resource base. In this light, as Powell and Edwards (2002: 5) observe, 'older people are now positioned as the solution to problems of demographic change, rather than their cause.'

'Own responsibility' is rationalized by state policy documents as reasonable linked to the increased incomes of the elderly; their heightened educational levels; a quality of better living, the traditional conception of the vulnerable elderly no longer holds true. All these set the stage for reinventing society's perceptions of the elderly as active participants in society capable of assisting in rescuing social provisioning to elderly care from imploding. Translated into policy, this new citizenship status -- referred to in this study as built on the value of positive ageing -- commands for the continued participation of the elderly in the work force; in community or voluntary work[14]; and towards one's own care in order to contribute to the regeneration of society.

At the gist of the various 'aspects of a future policy for older persons' (Ministerie van Volksgezondheid, Welzijn en Sport) is the normative value of participation. In this document, participation is basically understood as prolonged period of productive activity in the life span which allows the combination of 'training, caring and work' (life-course policy); built on the value of social cohesion, accept the inevitable shift to a selective welfare state; and administering social cuts to promote individual responsibility.

Some problems in the emphasis in the prioritization of positive ageing is already discerned in the document -- Social Welfare Act (WMO). Implemented in 2006, it is a document designed to create the necessary mechanisms toward facilitating the strengthened participation and sense of responsibility of the future elderly towards social care in the context of shared responsibility amongst *mantelzorgs* and municipalities. For instance, while positive ageing certainly views the elderly as participants in social life and are considered integral to the development of future policies to elderly care, the terms for dialogue to take place between the elderly and the state is highly suspect[15]. In this light, while recent

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[14] In light of an ageing population and the depleting human and monetary resource based towards social care, volunteerism and community work amongst the elderly is promoted in order to fill the gap created by the increased participation of women in the labour force (Powell and Edwards, 2001), the impacts of transnationalization and a society that is increasingly becoming more and more 'individualistic' (Ministerie van Volksgezondheid, Sport and Welfare).

[15] This analysis is borrowed from my previous essay submission to the 4306: Gender Policy and Planning Course in the Institute of Social Studies (Abella, 2007).

policy documents use the rhetoric of positive ageing, nowhere is it mentioned how this dialogical process is to take place besides handing the responsibility of managing (and strategizing on) social care over to municipalities and experts (See WMO policy document). Further, the linking of participation and citizen responsibility is highly problematic because it is constructed along the lines of a middle-age bias. To illustrate, the civil participation framework designed to supplement the WMO policy firmly asserts that participation of stakeholders in the process of developing future policies to elderly care is the sole responsibility of the citizen. It is implied in the document that elderly participation is guaranteed 'when a citizen comes into contact with municipal policy… when the citizen feels (directly) involved in a subject… and a person who does not envisage using home care services in the future will not bother to go to a public hearing or roundtable conference' (SGBO: 2006, version 2: 12). In this light, it is assumed that all elderly individuals are rational, able-bodied, capable and interested towards organizing public life.

Chapter no. 4
SOME FEATURES OF SHARED RESPONSIBILITY: BUILDING A COMMUNITY OF CARERS

In this chapter we look into some features of the lived realities of subjects of care. The first part reveals to what extent has the government redressed the inefficiency of the bureaucracy in the move from institutional care to home care. The second part looks at the impacts of society's biases in shaping the end of the life experience of the elderly. The third then moves on to a discussion on how a policy for the elderly built on the *mantelzorg* is unreasonable and how the unregulated space of the private and the utter disregard for relationships put very real pressures on the lives of the *mantelzorg.* In the fourth chapter, in using the case of the introduction of the PBG, we talk about how differentiating between the *mantelzorg* and the *thuiszorg* creates the necessary spaces to advance the interests of the markets and the privileged few.

4.1 'Managing' Shared Responsibility: The Bureaucracy and Administration

As noted earlier, the growth of home care is in part, a response to the people's outrage over the inefficiency of the bureaucracy and the de-personalizing effects of institutionalization. However, transferring elderly care to home care did not redress these problems rather, it was more a case of transferring or dumping certain aspects of care service onto the private sphere. As Collopy et. al. (1990: 4) notes, 'the home care system itself is thick with institutional structures and controls'.

The Netherlands is notoriously known for its highly bureaucratic, inefficient and cumbersome administrative systems. Based on the narratives of my informants (and personal observation), these burdens vary depending on the health condition of the patient; the availability of and existence of *mantelzorgs*; and educational background and income differentials.

Financing health care in the Netherlands is made up of a complex web of funding sources[16]. For instance, while all elderly informants convey nonchalance over the amount they pay for their health care, one elderly informant in this study who is without any surviving family members considers himself 'lucky':

> I am very lucky to be financially secure. I leave it up to the bank to manage payments toward my health care and the rest of my bills. I am alone in this world and I do not have any family members to care for. I do not represent the entire Dutch population of course and understand that it must be difficult for some individuals to meet the costs of their health care.

In terms of differentials based on one's health condition and absence or lack of informal care, it was noted by Ms A2 that the push factor that made her decide to engage towards the intensive care for her mother was when she saw that her mother began showing signs of forgetfulness (i.e. skipping her medication). Accompanied by Ms A2s husband, in one of their visits, her husband unearthed

[16] For a quick guide into the financing system of health care, refer to the policy document entitled *New Health Insurance System for Everyone* (Ministry of Health, Welfare and Sport, 2006)

piles of computer-generated messages, threatening to take Ms A1 to court for non-payment of fees. Regardless if payments were purposively disregarded by Ms A1, the point being put forward here it that a number of ethical problems arise when regarding the system as completely fixed, universal and de-personalized. In the one and a half years that these messages were being delivered to Ms A1s home, not a single person from the organization, neither the legal bodies came to check or even investigate on her condition. Further, as Ms A2 claims, oftentimes, people are faced with jargons that are incomprehensible even to 'rational minded and able-bodied persons.'

Additional problems noted against present-day set up of administrative systems also suggest the need to rethink the *thuiszorg's* communication system in efforts of creating a better and more responsive organization. While some elderly care receivers indicate that they have no problems waiting on line for 30 minutes to an hour (while being passed on from one department to another), *mantelzorgs* do not have the luxury of the time to wait on hold. At least three of the informants to this study (2 informal care givers and one elderly care receiver) mentioned the problems brought about by coordination and communication glitches. From missing out on forms and information sent by patients and their families to the *thuiszorg* by fax;[17] to messing up scheduled deliveries of meals to the elderly (in one case, one elderly woman in the woongemenschap did not receive her meals for two full days -- at 92 years, had she not been living in a private elderly community housing she could have easily succumbed to passing because of hung); and lack of coordination amongst the different 'specialized care providers,' notes the husband of Ms A2, 'at this point in time, one cannot afford to be lax... unless one is persistent as she is (referring to Ms A2), one will not be able to access quality care'.

4.2 The Marketized and Middle-Aged Biased Discourse of Palliative Care

Before the introduction of market principles and the notion of a consumer-client arrangement of social care in the 1980s, Knijn (Ibid) claims that there used to be a gendered but 'stable coalition of three systems of care'[18], In borrowing from the work of Clarke and Newman (1997: 7) Knijn (Ibid) explains that the co-existence of these gendered 'competing logics' was facilitated by strong family care (invisibilized in the public sphere), a 'bureaucratic commitment towards the service of the public interest'... and a 'professional knowledge (that served as the) engine of social progress and improvement which would enhance the public good[19].' In quoting one of my respondents whose mother received palliative care from a

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[17] In the case of Ms A2, the delayed response of the thuiszorg to her application for an upgrade of her mother's home care was explained as 'overlooked -- owing to the piles of commercial faxes that enter thuiszorg fax machines on a daily basis.'

[18] Kickert (1996) and Knijn (2001) makes mention of how the Dutch welfare regime was first founded on the logic of the bureaucratic and familial care systems. The professional care system was only introduced in the latter years when the redistributive mechanism of the state saw an expansion that began revealing the inefficiencies of following a purely bureaucratic care system and the pitfalls of paternalism, when following a purely familial care system.

[19] More concretely, the role of professional knowledge was to cushion the universalizing tendency of the bureaucracy, by providing specialized and particularized care.

nursing home back in the early eighties when home care was just beginning to be re-introduced into the health care system:

> I remember how it was for my mum when she was struck with cancer and we can no longer manage her care. Back then, the caring system felt more 'caring.' It was in 1984 or 1985 when we decided to put her in an elderly institution so that she can be monitored better. Because of the type of care she received from the institution, she was able to live for five more years.

Zooming in to August 2007, we witness a sharp contrast between the earlier practises of palliative care from today. Explains Ms A2, palliative care is now organized to be financed by the state for a maximum of six months. Any expense incurred beyond this six month ceiling will need to be borne by the patients. She adds:

> General practitioners (GPs) are discouraged from giving 'an indication' for palliative care unless extremely necessary. Because palliative care is very expensive and there was no telling how long my mum was to survive, we were advised and compelled to wait until the very last minute.

In the forward looking strategy paper *Policy for Older Persons in the Perspective of an Ageing Population* (2006), the Dutch government emphasizes its stand on 'quality of life and dignified dying' over 'length of life.' Dignified dying is understood as abiding to the wishes of the terminally ill to die in their 'own familiar surroundings' and 'euthanasia as a last resort can form as a dignified ending.' To this, the government asserts that the *mantelzorg* has a huge role to play in this.

Many ethical messages run through the Ministry's discourse. One, linking quality of life to dignified dying and de-emphasizing length of life, suggests that we should expedite the process of dying because the longer one lives and undergoes the 'deterioration process', the less a person s/he becomes. Second, again, the liberal values of preference and choice are being used to transfer the site of palliative care from the institutions to home care which emphasizes on, not surprisingly, the strengthened roles of the *mantelzorgs*. Finally, by drawing from the experience of Ms A1s passing, it is apparent that providing palliative care is a site of real conflict and clash between the *mantelzorg* and the *thuiszorg* which requires serious contemplation amongst policy makers. To quote Ms A2s narration of the end of the life experience of her mother:

> Initially, I could not understand why it did not register with her (the *thuiszorg*) that my mum's body was already rejecting the meds. She told me that she has no choice and she was obliged to follow the GP's instructions. After my mum passed then I realized that the *thuiszorg* was just following what she was told... she is a pawn in this entire business of professional medicine. Non-compliance would have meant losing her job. As much as it became confrontational between myself and the *thuiszorg* (who happens to be my friend), in the end, I realized how it was also a personal struggle in her part. When the GP finally came up to check on my mum, she expressed her frustration to the GP and told him that he will never be able to control her like that anymore.

4.3 The Fragility of an Elderly Care Policy Built on the Mantelzorg

Being a mantelzorg entails a lot of responsibility and commands an extreme amount of time. According to Visser-Janssen and Knipscheer (2004: 9), 'burden increases when the intensity of informal care is high, when people are helping a partner or child or when they are the sole informal caregiver.' Based on my interviews, all three mantelzorgs and elderly care receivers indicate that other fundamental problems are the questions posed by geographical distance; the incongruence between policy and today's 'competitive environment and work ethic;' the numbers of individuals being provided care for; and one's own health condition. All seem to agree that while home care seems to be working reasonably well right now, in the future, the government will have to rethink mantelzorg -- the reason being that:

> Families no longer live close to each other and neighbours come and go... It is an unfeasible and an irrational arrangement to obligate members of the family and the community to come provide care services for the elderly...Anyway, they also have their own families to care for and their own problems to attend to.

Ms A2, a cancer survivor, lived over an hour away from her ailing mother. In those past two years, she worked for three days in a week and the remaining days were spent caring for her mother; a daughter undergoing serious post natal depression; and her two grandchildren. As herself, both her daughter and her mother have their own households, in different provinces. Ms A2 has been without any vacation in the last two years and her break at a vacation was facilitated by the passing of her mother, Ms A1, in the summer of 2007.

In a 'perfect world,' all individuals must have the right to rest and leisure -- a right regeneration. We were not brought into this world to perform like robots and churn out our labour power. Rather than depicting human beings as instrumental to economic growth and performance, labour (like caring relations) must be seen as only one part of 'human flourishing' (Radin, 1996 in (Himmelweit, 1999: 37)). While only two out of the three *mantelzorgs* interviewed expressed over exhaustion, all three informants have personal health conditions themselves, suggesting that their limits are not taken into account by the present system.

Further, despite the many deaths that she had witnessed performing the role of a *mantelzorg* – including to two brothers-in-law and a friend's friend – Ms A2 has never overcome her fear of death and witnessing the pain and anguish of loved ones during their final hours or minutes. Ms A2 strongly argues for the need to institutionalize some form of professional help for *mantelzorgs* to assist them in the grieving process. She asserts:

> Professional helpers who witness the death of a patient are helped by an employed therapist to overcome the trauma of seeing a person pass on... but people like us do not receive any kind of assistance unless we show signs of extreme distress. Managing our traumas is often left in the private and only becomes a public concern when one is no longer able to function.

But how one assesses when a person is in need of a therapist or not is beyond the parameters of this study. In affirming the social scientists in the last two decades who critique the state as creating overbearing and overdependent citizens (See Knijn in Harrington Meyer, 2000: 237), the study also recognizes that there will always be some individuals who will exploit the system. However, the

existence of these 'alleged' parasites should not compromise the welfare of those in need. Hence, any policy solution under the restructuring process in general, and towards redressing the traumatic experiences of *mantlezorgs* will need to be done with prudence. Creating an application procedure accessible to *mantelzorgs* is only one solution. A caring and just society may also look into the possibilities of providing sufficient mechanisms towards responding to the 'traumatized' *mantelzorg* by eliciting a process that monitors the progress of previous *mantlelzorgs* within the grieving period at a certain period of time. If we are talking about shared responsibility -- we extend shared responsibility to also mean solidarity and social cohesion -- for a certain period of time -- even after the 'caring arrangement expires.'

Drawing from the experience of one elderly informant who witnessed the passing of her husband – 'had it not been for the compassion and intervention of their GP (the same GP who monitored her husband's health condition when he was still alive') -- I would not have had the opportunity to live this long.

4.4 *Mantelzorg* vs *Thuiszorg*

In here we will use the case of the differentiation between the *mantelzorg* and the *thuiszorg* the rigid distinction between both serves the status quo.

Surprisingly, despite the huge savings that the government is able to incur through a wider embrace of the home care option of PBG by the public, none of my respondents are users or beneficiaries of consumer-directed home care. Ms A2 describes the process of applying for consumer-directed home care a humiliating experience; too cumbersome; and too bureaucratic that at the end of the day, she and her husband decided to disengage in the process. Knijn (in Harrington Meyer, 2000: 244-45) links this cumbersome process to the deeply ingrained corporatist structure of the welfare state where, in the guise of a concern over 'quality care and unfair working conditions toward informal care workers' -- the former pillars in society, now managers of many public (and private) home care services -- resist the move to PBGs owing to the fear of losing clients. While resisting, at the same time they also find creative ways in capitalizing out of the PBG arrangement by 'providing administrative services to budget holders'[20] (Wiener et. al., 2003: 14) for the reportage process.

Ironically, while quality care and caring relations (or in this case conditions of informal care workers) are not focal towards informing the reconstruction process -- when it is invoked by players in the market -- it becomes a valid issue. Apparent here is the manipulation of the public and private boundaries of care, the social meanings of care -- which when useful towards advancing the interests of the privileged few, is used to rationalize policy decisions. The arguments used by the privileged few managers of home care is built on the continued dichotomization between the identities of informal care givers and formal care givers -- the separation of the institutions of particularized emotional care and universal rational care. This is also manifest in the report authored by Visser-Janssen and Knipscheer (2004: 12-3) who, while both rightfully arguing for the 'full acceptance of informal care by professional care givers,' emphasizes that such an arrangement allows 'professional care givers to work less patient-focussed and more system-focussed.'

[20] The authors to this report note though that capitalizing on this kind of service was not too successful in the sense that 'formal home care agencies already believe their payment rates are too low, so they are reluctant to provide their services fot he even lower rates budgetholders…' (Wiener et. al., 2003: 14).

As much as it is an argument that retains the divide between informal and formal care givers, as well, it provides a distorted picture of the love, care and/or compassion associated with (but invisibilized in) formal care. It assumes that paid professional work is not capable of providing emotional support to 'patients,' and that formal workers do not value the type of relationships formed in this 'caring transaction.'

In this light, I am drawn to the empirical arguments made by Himmelweit who makes use of Margaret Radin's notion of incomplete commodification.[21] Himmelweit builds a case that:

> Refutes the idea that caring and paid labour are incompatible poles of a dualism... Even when caring is paid, it tends to be incompletely commodified. This is because caring involves the development of sustained relationships between carer and caree, and these cannot easily be commodified (Himmelweit, 1999: 36-7).

The narratives of the two care givers who I interviewed suggest that they are especially drawn to elderly care beneficiaries who invite them for coffee or tea or for a small chat. Interaction with the *mantelzorg* is also valued and most appreciated which prompts them to do 'the extra mile' when administering systematic professionalized care. Interaction and caring relations are high on the agenda of all three personalities in the domain of home care but are hardly understood.

For instance, most elderly care receivers I interviewed value consistency in the formal care workers who come to render care service. Two elderly care receivers also mentioned that at this age, they no longer have the time to constantly build new relationships with new faces. One elderly explains that it is important for elderly care receivers to also understand the limits of formal care providers when he says:

> If I was to choose, I would prefer to be 'serviced' by the same care workers in *thuiszorg* ever single day. But this is not feasible -- *thuiszorgs* are human beings who also need to take a break from their work. Because I understand their limits, I was able to build good relationships with majority of the *thuiszorg* professionals who come to my house to render care service. The elderly must understand and be made aware of the limits of their carers.

[21] See Radin, M. (1996) *Contested Commodities.* Cambridge, MA: Harvard University Press.

Chapter no. 5
CONCLUDING REMARKS

In this study we discerned how the introduction of participatory citizenship in the restructuring process is marred with fundamental problems stemming from a practise in society that marginalizes the issue of care and caring relationships toward informing public decision and policy making. In this paper, we note that the issue of care, since the creation of welfare of the state, most often than not breaks through the barriers of the private sphere owing to its instrumental value. During the creation of the welfare state, it was instrumental towards 'keeping the citizenry happy' to encourage them to help out in the process of nation-state building and keep them from mobilizing and resisting the authority of the state; in the early 1970s, quality care suddenly became an issue because the state needed to find ways on how to streamline social expenditure; finally, the introduction of participatory citizenship became instrumental towards further reducing budgets toward home care. In sum, the invocation of enlarged social meanings of care (linked to a concern over quality care) in the public sphere was only administered to further advance the interests of state so engrossed towards embracing the neoliberal ideology to development. The welfare of the people was never really the central purpose.

By approaching the study using the lens of relations, we are able to delve deep into the politics of participatory citizenship and, based on the narratives of some of the study's informants, show why it fails to capture the insecurities and vulnerabilities of subjects of care. As we have noted above, the insecurities voiced out by most of the subjects of care pertain to vulnerabilities stemming from processes and relationships -- processes and relationships with the other actors of the subjects of care, as well as the system -- the bureaucracy and the marketized organization of the care system. All throughout we note how the discourse of the market and a middle-age bias shapes the boundaries of the public and the private sphere towards advancing the interests of a few privileged personalities and institutions... again... the welfare of the people was not the focus.

The problem is vulnerabilities and insecurities stemming from processes and relationship fail to be fully captured by the existing mainstream and alternative dimensions of social justice – redistribution, recognition and political representation. All dimensions of social justice are based on the notion of an autonomous individual who aspires to enter the domain of the public sphere. In these terms, the private sphere of justice is completely marginalized which is in itself an injustice because caring relations takes place in the unregulated private space of home care. By dangling the value of participatory citizenship, there is a tendency to move away from the central objective which is -- to rescue social provisioning for elderly care based on a conception of the dignified survival of all. Hence, the status quo is retained.

As I had explained earlier, our notions of our social realities are in a permanent state of flux. By deepening interrogation of the public sphere of decision making in restructuring elderly care, we are able to discern how the welfare of all may be enlarged. In this sense, departing from a conception of relationships and as such, enlarging the social meanings of care, is highly valuable in order to create a meeting point between the private interests of subjects of care (a welfare that translates in good relationships) and the public interest (rescuing social provisions to establish peace and order).

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