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Pushed to the Margins and Stretched to the Limit: Experiences of Freelance Eldercare Workers During the COVID-19 Pandemic in the Netherlands

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ABSTRACT

Eldercare professionals engaged in precarious work in the Netherlands faced shortages in personal protective equipment (PPE), testing, and staffing during the COVID-19 pandemic. This qualitative study of the health, financial situations, and paid and unpaid caring responsibilities of freelance eldercare workers illustrates how labor market inequalities have been (re)produced and exacerbated during the pandemic. Freelancers were pushed toward the margins of the labor market, working risky shifts and compromising their own interests, while unprotected by organizations, social security, or political efforts. Consequently, these workers were stretched to limits where they could no longer attend to their own health or to their paid and unpaid care responsibilities. The study places these empirical findings within Nancy Fraser and Rahel Jaeggi's theoretical work on capitalism, illustrating how eldercare workers found themselves at the center of boundary struggles during the pandemic.

KEYWORDS

Precarious work, COVID-19, intersectionality, capitalism, labor market inequality, elderly care

JEL Codes: B14, D63, I10

HIGHLIGHTS

- In the Netherlands, paid eldercare workers increasingly opt for freelance care work.
- During the pandemic freelance eldercare workers were seen as a health risk for clients.
- Some lost assignments; others were asked to work with insufficient PPE.

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- As a result, many struggled with moral and financial dilemmas.
- Unions and other players in the Netherlands hold conflicting views on freelancers in eldercare.
- These views stand in the way of building an alliance to enhance the situations of all working in the sector.

INTRODUCTION

In the Netherlands, just one month after the first COVID-19 patient was identified, 13,884 paid healthcare workers had tested positive for SARS-CoV-2, of which 458 were admitted to the hospital (National Institute for Public Health and the Environment [RIVM] 2020). People with migration backgrounds, those living in nursing homes, and healthcare workers were overrepresented (Kunst et al. 2020). Studies show severe physical and psychological impacts on health professionals caring for COVID-19 patients (Lai et al. 2020). The impacts are particularly severe for women, who comprise the vast majority of paid and unpaid caregivers, and as a consequence face considerable unprecedented dilemmas in balancing health, work, and family care (Li et al. 2020; Beroepsvereniging Verpleegkundigen & Verzorgenden Nederland [V&VN 2020]).

These are not “just” personal dilemmas. Structural inequalities of gender, class, age, and race have been exacerbated during the pandemic and the following “corona crisis,”[1] and illuminate existing labor market inequalities (Bhala et al. 2020; Kabeer 2020; Wenham, Smith, and Morgan 2020). Social disadvantages at the intersection of gender, race, age, and class mutually constitute each other, and to understand the experiences of different people during the COVID-19 pandemic, an intersectional perspective is essential (Verdonk et al. 2019; Hankivsky and Kapilashrami 2020). Intersectionality urges scholars to analyze how individual experiences are shaped at the nexus of race/ethnicity, gender, class, age, and disability/ability, and it aims to foster an understanding of how these intersections occur within connected systems of oppression, such as racism, ageism, patriarchy, and capitalism (Fraser and Jaeggi 2018).

Theoretical analyses made in the slipstreams of previous pandemics show how in the heat of a pandemic structural inequalities shift out of focus in favor of urgent biomedical needs. This disproportional focus on “urgent” and “essential” care needs has been called “the tyranny of the urgent” (Smith 2019), and “urgency” is shaped by existing power differences and hierarchies within the healthcare sector (Watts 2015). For instance, the gendered, classed, and racialized hierarchy between “cure” and “care” became prominent during the corona crisis. One example of this hierarchy is how intensive care units were favored in terms of finances and personal protective equipment (PPE), whereas the long-term care sector suffered from shortages of PPE and lack of access to testing (V&VN 2020).

In the Netherlands, the COVID-19 pandemic occurred against the backdrop of existing problems in the eldercare sector. In the aftermath of the global financial crisis of 2008, the Dutch government fostered austerity measures that included major budget cuts that were enacted through two new acts that aimed to reallocate caring responsibilities from higher professional levels to lower professional levels, and from paid to unpaid caregivers (Maarse and Jeurissen 2016). In addition, years of neoliberal policies had fostered precarious and flexible employment in eldercare, for example, through on-call contracts or temporary employment (Conen and Schipper 2019). As a consequence, paid care workers were increasingly stretched, as they had to conduct more complex care-related tasks at work, while also having more unpaid care responsibilities at home, under more precarious working arrangements. The Dutch experience of commodification, privatization, flexibilization, and devaluation of care work is comparable to that of other European countries, such as the UK.

Recently, the Netherlands has seen a rise in eldercare workers opting for self-employment, as an alternative to flexible temporary employment as a hired employee. The number of freelancers in health and social care has increased from 61,000 in 2010 to 91,000 in 2018 (Ministry of Health, Welfare, and Sport [VWS 2020]). In public debates and mainstream media, the rise in the number of freelancers is often framed as problematic from the perspectives of politicians, policymakers, and healthcare institutions. Freelancers are thought to disproportionally burden healthcare budgets, compromise continuity of care for clients, and fail to contribute equally to the social security system, as they pay lower income taxes. Unions have expressed concerns that freelancers undermine solidarity among care workers, and pension funds or interest groups have warned about their precarious employment conditions and lack of social insurance (VWS 2020). Although freelance care work is considered to be precarious work, it is important to note that its precariousness differs from that of other care workers in the Netherlands, such as live-in migrant workers (Bruquetas–Callejo 2019) or migrant domestic workers (Federation of Dutch Trade Unions [FNV] 2020), who suffered severely from the COVID-19 pandemic due to their migrant status and lack of access to social security.

In our ongoing, four-year research study, "Negotiating Health," we have explored freelancers' reasons to opt for self-employment and their experiences as freelance eldercare workers. Increasing time spent on accountability, decreased professional autonomy, increased care loads, increasing demands to be "flexible" and available at the expense of private life, health, finances and, especially for racialized care workers, experiencing racism in the workplace, were among factors that squeezed them out of the organizations and pushed them into self-employment. Since they felt changing the system would be impossible, their opting for

self-employment can be understood both as a coping strategy as well as an individualized act of protest against an exploitative system.

As the pandemic profoundly impacts their lives and work, we initiated this qualitative study to inquire into how the corona crisis affects freelance eldercare workers, particularly in terms of their health, financial situations, and paid and unpaid caring responsibilities. We aimed to understand from an intersectional perspective the mechanisms that (re)produced social inequalities within the COVID-19 pandemic and the subsequent corona crisis. In the discussion that follows we relate these mechanisms to Nancy Fraser and Rahel Jaeggi's (2018) theoretical work on capitalism and the concept of boundary struggles.

METHODS

As noted, this study is part of a large research project, "Negotiating Health," on the health and well-being of paid care workers, informal caregivers, and volunteers in eldercare, funded by the Netherlands Organization of Health Research and Development. This sub-study followed a qualitative interview design, and we place our work within the interpretative epistemological tradition (Green and Thorogood 2018).

Data were collected through semistructured interviews conducted by three interviewers (Duijs, Haremaker, and Bourik). Respondents were recruited via the professional organization for freelance healthcare workers, social media, and snowball sampling. Some respondents (R16–R23) included in this study were previously interviewed before the pandemic in the context of the broader study. We interviewed freelancers working in residential care (that is, nursing homes) and/or in domiciliary care (that is, home care). Respondents (N = 23) were purposively sampled across gender, age, occupational level, and migration status (Table 1).

Our topic list focused on the lived experiences of freelancers during the pandemic, including health concerns about COVID-19, balancing paid and unpaid caring responsibilities, concerns and dilemmas concerning others' health, financial concerns, (governmental) support, and experiences of marginalization and racism. Interviews were conducted by telephone, as government measures to reduce physical distancing did not allow face-to-face interviews. Interviews were conducted between March and May 2020, audio recorded and transcribed verbatim. Member checks were sent to the respondents to validate interpretations of the interviews.

In the first step of data analysis, we used thematic analysis (Braun and Clarke 2006) by identifying relevant themes and topics from the respondents' perspectives. Analysis was conducted manually by two authors (Duijs, Haremaker). In the second step, we (Duijs, Verdonk) applied an intersectional perspective to understand how the initial themes and topics were shaped by gender, class, ethnicity, disability, and age, which enabled

Table 1 Description of respondents

R.	*Age*	*Majority/minority*	*Unpaid care responsibilities*	*Relationship Status*	*Profession*	*Sector*
R1	32	Unknown	Children (12, 4)	Single	Unknown	Intra[c]
R2	40[a]	Surinamese-Dutch	Children (10, 8, 5), partner, and father	Long-distance relationship	Advanced Nursing Aide (level 3)	Intra
R3	51	Dutch majority[e]	Children (10, 16, 19, 21, 22)	Single	Advanced Nursing Aide (level 3)	Intra
R4	62	Dutch majority	No (older children)	Single	Advanced Nursing Aide (level 3)	Intra and Extra[d]
R5	60	Dutch majority	Mother-in-law	Married	Nurse (level 5)	Intra and Extra
R6	64	Dutch majority	Mother–in-law	Partner	Nurse (level 5)	Extra
R7	52	Surinamese-Dutch	Partner, family in Surinam	Partner	Advanced Nursing Aide (level 3)	Extra
R8	50	Dutch majority	No (older children)	Partner	Nursing aide (level 2)	Intra
R9	62	Dutch majority	No (older children)	Married	Advanced Nursing Aide (level 3)	Extra
R10	50	Dutch majority	Ex-caregiver for mother[b], parents-in-law	Partner	Advanced Nursing Aide (level 3)	Intra
R11	29	Moroccan-Dutch	No	Single	Advanced Nursing Aide (level 3)	Non-contracted
R12	29	Moroccan-Dutch	No	Single	Nurse (level 5)	Intra and extra
R13	32	Antillean-Dutch	Son with disability	Partner	Advanced Nursing Aide (level 3)	Intra
R14	40	Dutch majority	Ex-family caregiver[b]	Partner	Advanced Nursing Aide (level 3)	Intra
R15	60	Surinamese-Dutch	Unknown	Single	Nurse (level 6)	Non-contracted
R16	45	Dutch majority	Ex-family caregiver[b]	Married	Advanced Nursing Aide (level 3)	Intra
R17	60	Antillean-Dutch	Ex/informal caregiver[b], older children	Single	Advanced Nursing Aide (level 3)	Intra

R18	44	Dutch majority	Children (13, 11), father	Single	Client-supporter	Intra
R19	40	Moroccan-Dutch	Children (3), two with disabilities.	Married	Nursing Aide (level 1)	Residential
R20	52	Dutch majority	No	Married	Advanced Nursing Aide (level 3)	Extra
R21	58	Dutch majority	Mother	Married	Advanced Nursing Aide (level 3)	Extra
R22	62	Dutch majority	Husband	Married	Advanced Nursing Aide (level 3)	Intra
R23	37	Antillean-Dutch	Mother in Curacao	Married	Advanced Nursing Aide (level 3)	Intra and Extra

Notes: [a]The age of this respondent is a rough estimation, as she did not wish to disclose it. [b]"Ex-family caregiver" refers to those who were, until recently, informal caregivers for partners, family members, or others. [c]"Intra" refers to residential care (for example, in nursing homes). [d]"Extra" refers to domiciliary care (home care). [e]With Dutch majority we refer to people who are members of the (white) majority population in the Netherlands.

a more in-depth understanding of the societal inequalities that were reproduced and how (Verdonk et al. 2019; Hankivsky and Kapilashrami 2020). Data saturation did not occur in relation to racialized inequalities, nor have we been able to include men in our study. These themes required further exploration, which was hindered by time constraints.

This study was evaluated by the Medical Ethical Review Committee of the Amsterdam University Medical Center (UMC), location VUmc, Netherlands, which confirmed that the Dutch Medical Research Involving Human Subjects Act did not apply. Data was stored anonymously at the internal network of Amsterday UMC and will be archived until five years after the study, "Negotiating Health," has been completed. Informed consent was expressed orally over the telephone and was audio recorded. Informed consent forms were sent via email to ensure access to important information that was mentioned on the form.

RESULTS

To illustrate the pandemic's disruptive effects and deepening of inequalities, we first describe how the COVID-19 pandemic impacted freelance workers by pushing them to the margins of the labor market. Second, we present how inequalities subsequently play out in the freelancers' morally stressful navigation between paid and unpaid care responsibilities, which stretch them to the limit.

Pushed to the margins of the labor market: Freelancers' unprotected care work during the COVID-19 pandemic

For many respondents, self-employment symbolized the freedom to attend to their own health, informal caring responsibilities, and financial obligations, free from unhealthy organizational practices, such as unlimited demands for flexibility or having to endure racism in the workplace. Opting for self-employment in times of staff shortage strengthened care workers' perceptions of earning secure incomes as freelance care workers, while creating more meaningful work. The COVID-19 pandemic disrupted these conceptions of freedom and laid bare the precariousness of freelance care work.

A confrontation with precariousness of work

All respondents experienced their flexible care work being framed as a health risk, and institutions and individual clients feared that freelancers would form a vector for infection. As a result, many freelancers were actively kept out of workplaces, or clients required exclusivity, which compromised freelancers' income, as tax rules required them to have at least three clients

per year. Those with a financial buffer could actively choose to withdraw or minimize their client base to protect their own health as well as their clients. Those in financially precarious situations expressed how this made them feel vulnerable, exploited, or pushed aside:

> You think you've got a lot of freedom, but it isn't that much. It's five days since the coronavirus is here, and I have lost most of my work. And then there's nothing you can rely on. It's not only a financial hit, but also an emotional one. (R11)

Other respondents mentioned how they were immediately confronted with the risk of being crowded out of the labor market:

> My problem is this. On the one hand, you're being pushed out as a temp or self-employed, but on the other hand, there is a massive demand for everyone with a healthcare background who, for example, are now suddenly allowed to work in healthcare. (R5)

Respondents of color shared how they were excluded from care teams while their white colleagues were not, suggesting that these decisions are also shaped by racism. Respondents with limited financial means sometimes had to withdraw involuntarily as they were dependent upon public transportation and were unable to get to work due to adjusted timetables, or were afraid to travel by train as they feared infecting their clients. They often chose to prioritize the health of their clients over their financial situations, but as a consequence, their already-limited financial means were depleted further.

This problem was especially impactful for single mothers who were sole breadwinners: "We can't really afford to stay home for a day. A day without work is a day without money" (R1). The financial consequences of being kept out of the workplace hit them hard, while the older, white, single, and/or higher-educated respondents often expected to be able to fall back either on financial buffers, partners' incomes, or early retirement, or did not worry as much about financial adversity as they had to take care of "only" themselves. They did not immediately experience the situation as precarious.

Working the risky shifts

While on the one hand freelancers were kept out of the workplace, on the other hand several respondents received increasing requests to work in institutions with COVID-19 patients, while lacking access to adequate personal protective equipment (PPE): "Yes, the requests are far more

frequent – 'Would you like to work with us? Oh, by the way, we do have COVID-19'" (R12).

Respondents explained these requests in terms of the sharp increase in hired (non-freelance) employees going on sick leave to protect their own health, supported in this strategy by trade unions, professional organizations, and their employers (V&VN 2020). Freelancers were not always informed about the presence of COVID-19 patients, which made an informed decision whether or not to accept a certain shift impossible. Freelancers who provided noncontracted care (that is, caregivers not contracted by insurance companies, who often provide care directly purchased by clients) faced different challenges. Some were requested to co-quarantine with clients to avoid the risk of transmission to clients by caregivers, and some even ended up in involuntary co-quarantine:

> I just got called from a befriended freelancer who takes care of a corona patient. She's been covering several twenty-four-hour shifts now, but no one is willing to take over … A burnout is about to happen. For me, it's too far away, otherwise I would have helped her. Noncontracted care workers, they can't withdraw. They have a duty to provide care; they're the only ones responsible. The dynamics are very different. (R15)

Unprotected work

Freelancers lacked access to social protection. They felt they would not be covered by social protection measures for freelancers who lost their work due to the COVID-19, as they expected that these would not be granted to freelancers in the care sector: "As a self-employed care worker you can't really say, 'There is no work to do.' There is plenty. Health care didn't stop. If you're not working, well, that's your own choice" (R17). They were also not served by governmental efforts to redistribute PPE. Eldercare was at the bottom of the care–cure hierarchy, to the great frustration and anger of respondents:

> From the start, I was irritated by the fact that all attention went to the hospital. True, on intensive care, people's lives are saved. But the nursing homes are completely left to themselves. It's not just shortages, because, let's be fair, it's also just indifference. (R7)

After public debates, the regulation was revised a few weeks into the pandemic, which gave more priority to nursing homes: "but not for self-employed and neither for the small homecare organizations. So, well, we missed the boat anyway" (R23). Freelancers with shifts in nursing homes could benefit from PPE in the institutions, but freelancers providing

noncontracted homecare had to pay extortionate prices for PPE in the free market. Simultaneously, some care workers' financial situations were compromised by outstanding payments from health insurance companies and/or care organizations for work done in the past months, which now became an acute problem: "Some just don't have the money to buy this expensive protective equipment" (R15). The lack of sufficient PPE for caregivers on the frontlines was also a source of great frustration and anger:

> We're being sent to the front without weapons. This really irritates me. I have to care for my clients without protective equipment, but when I have to go to the team leader, I must hold a six-feet distance. Yeah right, you feel safe and we have to care with the risk of sacrificing our own health. (R12)

Political and societal disregard for freelancers in eldercare became especially painful for freelancers during the COVID-19 pandemic: "So much has been said about the self-employed, they want to push us aside, but now they need us badly" (R12).

Stretched to the limit: Navigating moral minefields during the COVID-19 pandemic

As freelancers were pushed toward the margins of the labor market, their health, unpaid caring responsibilities, and financial situations were increasingly put at risk. Freelancers in pandemic areas, who also had informal care responsibilities but did not have financial buffers, felt stretched to the limit and found themselves having to make harsh choices. They were no longer able to negotiate looking after their own health while caring for the health needs of others. In a landscape of gendered, classed, and racialized inequalities, they entered moral minefields in which they tiptoed between their own health, the health of others, and their financial situations.

Harsh choices

The intense dilemmas caused by this moral minefield of care become tangible in the story of an Antillean-Dutch mother who carried out informal caring responsibilities at home for her son who had asthma, and who was able to protect the health of her son by relying on the income of her partner:

> We're care providers, we're also mothers, we're also someone's daughters, we're also aunts, someone's cousin or niece. You do this work from your heart, but not at the cost of your private life and

> putting your own life at risk. I am devoted to my work, but my child needs me too. Get it? It's so contradictory. From whatever perspective, you want to do your job, assist your colleagues, but you're being restrained because there's no safety. It's hard, so then you decide to stay home. But then you feel guilty, too. There are people out there who need help and there are shortages of staff. I want to be there. But if I'm there, I might infect my son. And then I wonder: is this worth doing? My thoughts are going both sides all the time. (R13)

Several other respondents shared how they felt "stuck in the middle, having to make harsh choices," such as the 52-year-old freelancer who migrated from Surinam and who felt forced to protect the health of her partner by withdrawing from paid work, which not only compromised her own financial situation, but also her ability to (financially) support her family abroad. She expressed guilt and shame and felt alienated from herself, as she was no longer able to attend to her caring responsibilities:

> I've got brothers in Surinam with families ... I used to support them monthly, but I can't do that anymore, at least not as much as I used to ... That's the mean thing about this whole situation, your thinking is increasingly in terms of 'I.' Yes, and I hate myself for this, because that's not how I am. I just can't afford to give everything away right now. (R7)

The caring identity and the ideology of self-sacrifice

The moral values expressed by care workers, such as protecting the health of intimate others, expressing solidarity with colleagues, and the responsibility to care for clients are characteristic of their caring identities as women. This identity puts care workers in a bind. Even if refusing to work shifts was financially possible and necessary to protect their own health and the health of others, choosing not to care for clients meant they had to compromise their caring identities, as voiced by this older freelancer who stopped working to protect her own health:

> You feel guilty. You know that you have good reasons not to go. But it just sticks in your mind. When I watch telly, I see people grab their uniforms out of their wardrobes after many years. And then I look at myself, sitting home, being the experienced one. I'm 60 already. I had to reassure myself over and over again. (R17)

Pushed in a corner: How money trumps everything

Moral considerations (moral minefields) are overshadowed by financial struggles, as was expressed by this 32-year-old single mother of three, who worked in the epicenter of the pandemic:

> At the moment, it's just the financial part that's causing me stress, because the bills need to be paid, otherwise you'll risk falling into severe debt. If I had to choose between my own health and my financial situation, I think I'd go for the latter. Ill health or good health, I would just go out working. (R1)

Her story illustrates how the experiences of freelancers are largely shaped by class; being able to attend to your own health and the health of others became the preserve of those with the financial means to do so. Not everyone could afford a moral dilemma. For some, working in the pandemic was plain survival.

DISCUSSION

In this study, we show the mechanisms behind the exacerbation of existing inequalities in the corona crisis. Using two themes, we illustrate the pathways through which gendered, classed, and aged inequalities are perpetuated and reinforced. First, in the COVID-19 pandemic and the following corona crisis, freelancers were "pushed to the margins," as the precariousness of freelance care work was exposed at multiple levels. Second, freelance elder care workers endured and had to navigate moral minefields as their paid and unpaid caring responsibilities were "stretched to the limit."

We position our empirical findings within Fraser and Jaeggi's (2018) theoretical work on capitalism. They theorize that interconnected systems of oppression, such as class, patriarchy, racism, and environmental injustice, are deeply rooted in the institutional structure of capitalism. Fraser and Jaeggi (2018) conceptualize four background/foreground divisions in capitalism: structurally separating economic production from social reproduction (that is, a gendered division of "work" and "care"), economy from polity, human from nonhuman nature, and exploitation from expropriation (a classed and racialized division). Capitalist economies do not exist in the absence of public power, social reproduction, expropriation at the (non-Western) "periphery," and inputs from nature. Yet, simultaneously, capitalism disavows the value of these realms for economic production, as well as their intrinsic value. Viewed as infinite free gifts to the economy, capitalism does not recognize the need to replenish them.

These background conditions are not infinitely elastic, and therefore struggles occur in each of these four realms, conceptualized as "boundary struggles" (Fraser and Jaeggi 2018). We understand the dilemmas, emotions, and acts of resistance of freelance eldercare workers as markers of these boundary struggles, expressing anxiety as they feel stretched too far and as they make (implicit) moral judgments over unjust structures. The gendered, classed, and racialized hierarchy of the health system is laid bare before their eyes, as those working in higher-educated, white, medical, technical, and male-dominated sectors are better protected than those working in the eldercare sector, where care work is performed relatively often by the bodies of less-educated women of color (Watts 2015; Fraser and Jaeggi 2018).

First, we turn to the production/reproduction division, which has been extensively theorized by Marxist feminists as a source of gendered oppression of women in capitalism, as production is traditionally associated with men and reproduction with women (Fraser and Jaeggi 2018). Social reproduction refers to forms of paid and unpaid provisioning, caregiving, and interacting that produce and maintain social bonds, called "care" or "affective labor," which take place in households, neighborhoods, and families, but also in public institutions such as schools and eldercare centers. Before the pandemic, austerity measures relegated paid care work in the welfare state to the sphere of unpaid care in the community. The reason for this shift was that eldercare was not "productive enough," not profitable, and too costly for the welfare state. These measures have increased gender inequalities in the Netherlands, and rendered social reproduction invisible again (Duijs, Verdonk, and Abma 2019). The corona crisis painfully illuminated how the world's formal economies and the maintenance of our daily lives are built upon invisible, devalued, and (in)formal care work mostly done by women. Our study shows how the pandemic exhausted freelancers' paid and unpaid reproductive work, as they had to make harsh choices between their paid and unpaid caring responsibilities. Their unpaid reproductive work threatened their paid reproductive work and vice versa. The corona crisis thus exhausted the reproductive work of these freelancers up to a breaking point, which can both be understood as a broader "crisis of social reproduction." The fact that the recent austerity measures in the Netherlands indirectly caused the dilemmas that care workers faced during the pandemic did not lead to societal discontent or political debate. The feelings of shame and guilt displayed by respondents in our studies illustrated how their dilemmas were strongly individualized; they felt personally responsible for being unable to attend to both their paid and unpaid caring responsibilities, rather than blaming life in a system that set them up for these dilemmas and ultimate "failures."

Second, our study illustrates boundary struggles at the economy/polity division. Eldercare workers who were squeezed out of the organizations of the welfare state and into self-employment had shifted from the public domain (polity) to the domain of the free market (economy). Our study shows how the corona crisis plunged them into precariousness, and as a result, boundaries started to be questioned. During the COVID-19 pandemic, the Dutch government showcased an unprecedented intervention in the healthcare sector, yet freelancers were not served by these political efforts, as, according to politicians, they had to take care of themselves in the "free market." While freelancers in other sectors could rely on governmental support, as could hired employees within the eldercare sector, freelancers in the eldercare sector appeared to be falling through the cracks. This "intersectional policy failure" (Hankivsky and Kapilashrami 2020) led to debates in mainstream media and advocacy by professional organizations to shift the boundary toward including freelancers in public and political efforts to protect and support eldercare workers. These boundary struggles are ongoing, as the role and position of freelancers in eldercare is on the political agenda (VWS 2020).

Third, Fraser and Jaeggi (2018) address boundary struggles between human nature and nonhuman nature. This boundary struggle is more difficult to pinpoint directly within the context of our study, although both scholars and public organizations such as the World Wildlife Fund International, World Health Organization, and United Nations have pointed toward the link between the COVID-19 pandemic and the destruction of nature (Carrington 2020; Lambert et al. 2020). Recently, health scholars have articulated more fiercely that climate change is a major public health issue (Watts et al. 2018). While the boundary struggles of production/reproduction and economy/polity were defensive, trying to shift the boundary back, this particular boundary struggle, of human/nonhuman nature, is transformative, as the very existence of the boundary was questioned. The pandemic shows how human and nonhuman nature are deeply intertwined, impacting the bodies, lives, and work of those working in healthcare.

Last, we turn to the boundary struggle at the exploitation/expropriation axis. Fraser and Jaeggi argue that in current financialized capitalism,

> expropriation is becoming universalized ... where low-waged precarious service work is replacing unionized industrial labor and governments are cutting public goods and social services at the behest of investors, capital is now routinely paying the vast majority of workers less than the socially necessary costs of reproduction. (2018: 107)

As one result, people become dependent on debt to sustain themselves. In the present case, while the push into self-employment was a response

to exploitation, the COVID-19 pandemic caused freelancers to fear indebtedness or dependence on their partners' incomes, thus increasingly fearing expropriation. For many, their very financial independence was under threat.

In past years, healthcare workers' salaries have been hotly debated in the Netherlands. These boundary struggles intensified during the corona crisis, with outcries over "underpayment" of care workers in the media and with unions using the pandemic to advocate for higher salaries. Furthermore, Fraser and Jaeggi (2018) understand expropriation as historically shaped by racialized inequalities. In the Netherlands as elsewhere, the corona crisis collided with an uprising of the Black Lives Matter movement and the growing acknowledgment of racism as a public health issue (Devakumar et al. 2020). In this study we observed how the experiences of freelancers were shaped by institutional racism, as respondents of color were overrepresented in lower-educated sectors, and by cultural racism, as respondents of color were pushed toward freelance work due to experiences of everyday racism in the workplace.

In conclusion, our study shows how freelance eldercare workers' experiences are shaped at the nexus of all four of capitalism's divisions, and how boundary struggles occur at all levels. It is no surprise that these struggles erupt so acutely in eldercare, as neoliberal policies and austerity measures in the aftermath of the financial crisis have left the sector overstretched and underserved and, thus, crisis prone. A failure by those in power to understand how the gendered, classed, and racialized dynamics that disadvantage eldercare workers are interwoven into capitalism's broader social order will push freelancers further into precariousness. Governmental organizations, politicians, unions, professional organizations, pension funds, and other parties in the Netherlands hold conflicting views concerning freelancers in eldercare. These conflicting views stand in the way of building a broad alliance that can enhance the situations of those working in the sector. In this paper, we provide inputs for a dialogue that requires shared actions among diverse parties. Because as Fraser and Jaeggi note, "Only by joining a robustly egalitarian politics of distribution to a substantively inclusive, class-sensitive politics of recognition can we build a counterhegemonic bloc that could lead us beyond the current crisis to a better world" (2018: 223).

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NOTES ON CONTRIBUTORS

Saskia Elise Duijs MSc, has a background in biomedical and health sciences and researches and teaches in the Department of Ethics, Law and Humanities at Amsterdam University Medical Center, location VUmc. She has conducted several participatory health research projects with diverse client and professional groups. She currently works on her participatory PhD research into the experiences of paid and unpaid caregivers in eldercare from a critical gender and intersectional perspective.

Anouk Haremaker is a bachelor's degree student in health sciences at the VU University in Amsterdam. She conducted her internship in the Department of Ethics, Law, and Humanities at Amsterdam University Medical Center, where she wrote her bachelor's thesis on the experiences of freelance eldercare workers during the COVID-19 pandemic. She aims to specialize in global health and hopes to contribute to solving health problems worldwide. In addition to her studies, she has developed a passion for field hockey, which she has played for twelve years.

Zohra Bourik, MSc, has a background in Middle Eastern studies. She has worked as a social worker to support the empowerment of young girls and women. She is currently a junior researcher in projects on the health and well-being of vulnerable groups. Outside academia, she works as a trainer and educator to prevent domestic violence and child abuse.

Tineke A. Abma is Professor of Participation and Diversity in the Department of Ethics, Law, and Humanities at Amsterdam University Medical Center and Executive Director of Leyden Academy on Vitality and Aging, Netherlands. Her work is focused on the involvement of users, including older people, in research, policy, and care. She has been involved in long-term projects in the fields of psychiatry, eldercare, and chronic care, and her work has been recognized for its high societal impact. Professor Abma is author/editor of a number of articles and books, including *Evaluation for a Caring Society* and *Participatory Research for Health and Social Well-Being*.

Petra Verdonk is Associate Professor at Amsterdam University Medical Center and trained as an occupational health psychologist. She has written many articles, reports, and chapters on gender, work, and health such as on gender and burnout among general practitioners, work-related fatigue in highly educated women, return to work among young highly educated women with burnout, and menopause and work.

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NOTE

1 With the term "pandemic" we refer to the outbreak of the SARS-CoV-2 virus and the pandemic of patients suffering from COVID-19 as a consequence of infection. With the term "corona crisis" we refer to the societal impact of the pandemic, such as the policy response measures and the economic crisis.

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