Dignity of dependence: welfare state reform and the struggle for respect
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Citation for published version (APA):

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Chapter 7

Conclusions
The appeal to 'active' citizenship

European welfare states are in transition due to social, demographic and economic developments that are challenging their sustainability. After a period of welfare state expansion under highly favourable circumstances between the 1950s and 1970s, mature welfare states now face the pressures of growing needs and limited resources (Pierson 1996). In the field of care, three main developments contribute to these 'new' social risks (Taylor-Gooby 2004). First, the increased labour market participation of women has led to the receding of the ‘male breadwinner model’ and the ‘natural’ availability of women as family care-givers (Lewis 1992). Second, growing longevity and numbers of the elderly have changed the ratio between the working and non-working populations; the resulting old age dependency ratio puts pressure on public care spending, the supply of care labour, and the intergenerational social contract (Bonoli 2005; Goerres & Tepe 2008). Third, the imperative of economic competitiveness in a globalised market urges governments to adapt their care policies to financial developments such as the recent economic crisis that began in 2007-8 (Taylor-Gooby 2004; Clarke 2010).

To respond to the growing ‘care crisis’ (Hochschild 1995), many European welfare states are pursuing policies to off-load public responsibilities for long-term care (Newman & Tonkens 2011). Instead of ‘passively’ consuming rights bestowed by the welfare state, citizens are encouraged to become more self-reliant, either by anticipating their own care needs (e.g. private or individual saving schemes) and/or by seeking private arrangements (e.g. family or community care) (ibid.). The appeal to ‘active’ citizenship is framed as furthering citizen voice and empowerment; it invites people with disabilities and chronic illnesses to participate in decision-making and to co-create care arrangements in their communities (Newman et al. 2004; Newman & Tonkens 2011). But this participative discourse also assumes that vulnerable citizens can rework their claims for full and equal participation in a reformed welfare state in which citizens enjoy fewer rights.

The reform of long-term care policy affects both the redistribution of care and the recognition of care needs (Newman & Tonkens 2011). Redistribution in the ‘classical, post-war welfare state’ as outlined by Keynes and Marshall (1965) entailed the redistribution of resources in the struggle against socio-economic
injustice. In many mature welfare states, publicly financed care is increasingly reserved for those who are deemed most in need (Rostgaard et al. 2011). Even generous welfare states such as the Nordic countries and the Netherlands are making access to public long-term care much more selective. Different combinations of monetary (e.g. income), medical (e.g. severity of disability) and moral (e.g. family care norm) barriers restrict care to citizens who cannot assume ‘active’ responsibilities. Alongside the more stringent logic of ‘proportional justice’ (Foster 1983) applied to existing long-term care schemes, new policies include programs that are not codified in law or which fall under ‘framework’ legislation (Cox 1998). Municipalities – to which many of the previously national responsibilities for long-term care have been devolved (Trydegård & Thorslund 2001; Cochrane 2004; Rostgaard et al. 2011) – are thereby free to organise local, ‘tailored’ care services (also ‘creative justice’, see Foster 1983) that often focus on providing ‘help-to-self-help’ (Vabø 2011, 2012). Universal entitlement to collective care insurance built on the idea that ‘everyone pays, everyone gains’ is now considered a ‘passive’ form of solidarity (Trappenburg 2009).

In contrast, the recognition of care needs entails identity-related struggles against cultural or symbolic injustice, institutionalized patterns of cultural value that express (dis)respect for citizens and define opportunities for achieving social esteem (Fraser & Honneth 2003). Recognition as respect and esteem is a vital human need as it shapes one’s identity; non-recognition or misrecognition can inflict serious harm (Taylor 1992). The struggle for recognition becomes more salient as redistribution recedes (Fraser 1995), while the dichotomy of active/passive citizenship increasingly stigmatizes reliance on public services through its portrayal of a negative ‘dependency culture’ (Fraser & Gordon 1994; Lister 2001). This means that it is now more difficult for citizens to have their care needs recognized as a public responsibility and to derive respect and esteem from depending on public services. Welfare state retrenchment thus entails more than changes to rules, rights and responsibilities; it defines what citizens are worth and how they are supposed to ‘feel’ about public versus private care arrangements. This thesis therefore not only examined the practical consequences of long-term care reform, but also how citizens experience the new identities that governments seek to bestow on them as part of an ‘emotional reform’.
Dutch long-term care reform: from rights to favours

The Dutch care reform agenda is particularly interesting in this broader process of welfare state ‘retrenchment’ (Pierson 1996, 2001). The Netherlands was often seen as an international leader, upholding one of the most generous and comprehensive long-term care schemes for people of all ages (Pavolini & Ranci 2008). But in the period 2003-2005, the government’s care reform agenda broke sharply from previous policy. For the first time in the history of the Dutch welfare state, the government cut back entitlements to publicly financed care, even for current beneficiaries. Incremental amendments to the rights-based Care Act (ABWZ) have reduced access to both services (care in kind) and allowances (cash-for-care or personal budgets), especially for people with relatively mild disabilities. The reasoning is that public care is reserved for those who ‘really need it’ (VWS 2008, 2013a) – suggesting that too many people had shamelessly been claiming public money.

Citizens with ‘less urgent’ needs are now subjected to the Social Support Act (Wmo, enacted in 2007). Unlike the national long-term care insurance (AWBZ) with its (increasingly selective yet) fixed care rights, the Wmo is a framework law that allows municipalities to replace absolute with negotiable claims (Cox 1998a). Municipal representatives now negotiate public/private care responsibilities with citizens during a home visit, or ‘kitchen table conversation’. The ‘negotiation’ is value-laden as publicly financed care is only granted when all private options (e.g. family care, voluntarism, etc.) have been exhausted. In effect, the introduction of the Wmo (also ‘Participation Act’) marks the Dutch long-term care system’s turn to an ‘informal care-led’ welfare model (Ranci & Pavolini 2008).

The turn to informal care (i.e. care that is not provided for pay and/or by professionals) is not only considered financially necessary but desirable in itself. At the heart of the reform agenda is the belief that citizens have become too dependent on public services: extensive (home and residential) care services have led to the social isolation of citizens with disabilities and the crowding-out of private initiative. To revitalize civic engagement, the Dutch government not only encourages the informal exchange of care but sees this as the way to transform society and repair the ‘broken moral economy’ (Clarke & Newman 2012). Alongside the supposedly altruistic, loving, warm, and durable nature of
informal care, the government’s ‘community spirit mantra’ (cf. Eliasoph 2011) emphasizes the positive effects of informal care exchange for social cohesion and democracy (VWS 2007). The Dutch government thereby presents welfare state retrenchment as a ‘virtuous necessity’ (Clarke and Newman 2012) and claims credit for enhancing ‘active solidarity’ among citizens (Trappenburg 2009) while justifying (the social costs of) retrenchment by appealing to the higher goal of ‘saving’ the collective long-term care scheme for current and future generations (Pierson 1996; VWS 2013a).

Pierson’s (2001) differentiation between strategies to reform the welfare state – cost containment, recalibration and recommodification⁴ – provides insight into Dutch government strategy. The ‘problem’ of rising demand and shrinking resources is not addressed by reducing but by enlarging the distance between care-givers and the labour market (‘decommodification’⁴ rather than ‘recommodification’). Citizens are encouraged to provide (more) unpaid care to their relatives, neighbours and communities on the basis of altruism, substituting previously paid services. The premise is that care is either provided ‘for love’ or ‘for money’ (Folbre 2012) and that unpaid, informal, ‘warm’ care is superior to paid, professional care (cf. Hochschild 1995).⁵

To examine how citizens experience the changing norms on the ‘right way to depend’, we focused on care recipients and their relatives affected by recently tightened medical and moral barriers to access to publicly financed care. First, the ‘AWBZ pakketmaatregel’ enacted in 2009–2010 mainly targeted ‘social care’ (as opposed to medical and bodily care, for which universal rights still remain).⁶ Due to this reform, approximately 60,000 people with relatively ‘mild’ disabilities lost their entitlements to support for daily living (even more had their entitlements reduced) (CIZ & HHM 2008). The lost support consisted of assistance with daily living in and outside the home or institution (e.g. shopping, going to the hospital, handling the mail) and support with social participation (e.g. elderly day-care) – rights that were once considered the ‘triumph’ of the public recognition of disabled and elderly persons’ needs (Newman & Tonkens 2011: 14). Affected clients were encouraged to (re-)turn to their own private networks and/or communities for help – framed as enhancing ‘self-reliance’⁷ or one’s independence and autonomy vis-à-vis the state. Second, the tightening of the ‘customary care’ norm (2009) increased the family care responsibilities of household members, which are not eligible for public funding. Affected relatives
who are confronted with these mounting care duties are encouraged to view these as an act of 'active' solidarity (Trappenburg 2009) in the context of the Wmo.

**Clashing moralities of 'self-sufficiency'**

Empirically – based on a survey, the analysis of letters of complaint, and personal interviews with affected clients and their family care-givers – this thesis found that citizens struggle with the new demands of ‘active’ citizenship. Many felt trapped in moral dilemmas regarding their autonomy (among care recipients) and altruism (among care-givers).

*The autonomy trap*

Disabled and elderly citizens facing shrinking entitlements to care were not attached to their previous rights per se, but to the autonomy these rights gave them to live their ‘own, independent’ lives. Alongside reduced psychological well-being, the survey revealed that most affected clients saw increased dependence on their own private networks as the most problematic effect of the reforms. The personal interviews revealed that disabled and elderly persons do not find the statement ‘I need help’ particularly shameful, so long as the need can be managed. They saw (the previously received) publicly financed care as essential for their autonomy in two ways. First, using professional care allowed them to receive care relatively anonymously and to uphold an image of ‘self-sufficiency’ in the eyes of family members and friends. Second, by using a personal budget to pay for informal care, care recipients felt that they could distinguish between care and social relations, thereby equalizing one-sided dependency. Client understandings of autonomy thus contrasted sharply with that of the participatory discourse, which sees autonomy and independence as self-reliance vis-à-vis the state.

Given the reduced choice between professional/paid and informal care, interviewees experienced the ‘nakedness of shame’ – of ‘losing control over what is being revealed’ about their frailties and to whom (Sennett 2003: 117). Affected clients did not want their kin to ‘buffer’ welfare state reform. When possible, affected clients hid or repressed their (persistent) care needs from their relatives to avoid their (further) involvement. Such masking of need also
demands the masking of emotions, of telling family and friends that one is ‘just fine’ while feeling devastated inside. This ‘strategy’ to preserve one's autonomy from one’s private network often leaves disabled and elderly persons less ‘self-reliant’ than before the reforms.

The altruism trap
Family care-givers affected by welfare state retrenchment likewise struggle with the new demands of ‘active citizenship’. They are expected to provide more care for their co-resident relatives and see this as ‘customary’. Most informal care-givers indeed refer to intrinsic motivations to care for their kin: ‘it is normal to do so’ (Timmermans 2003; Dykstra & Fokkema 2007). But the simultaneous introduction of the ‘customary care’ norm in assessment procedures and personal budgets in the late 1990s created the possibility for informal care-givers to set boundaries to their unpaid, ‘non-customary’ care-giving. Approximately 84,000 informal care-givers performed ‘non-customary care’ in return for pay via the personal budget (Knijn et al. 2009). Under the current reform agenda, payment for informal care via a personal budget is increasingly seen as an ‘unintended use of [public] resources’ (VWS 2008: 202).

With the cutbacks to the AWBZ and the more demanding ‘customary care norm’, the care provided by relatives is increasingly reframed as ‘support’ rather than ‘care’ and as ‘charity’ rather than ‘work’. In other words, the dichotomy between caring for love and caring for money has been sharpened (Folbre 2012) as the ‘community spirit mantra’ emphasizes altruistic motives for care-giving. Care-givers affected by the reforms thus feel misrecognized, that their extensive care work has been devalued. Some even feel abused for their personal commitment: having taken on ‘non-customary care’ for their relatives, sometimes at the expense of paid employment, the cutbacks and extension of the customary care norm oblige them to perform the same care without pay. They also feel trapped in their predicament: as they primarily provide care for altruistic motives, they cannot morally reject the continuation of their care-giving when the payment stops (Ramakers & Van den Wijngaart 2005). Family care-givers then have to suppress their feelings of anger and continue providing care as ‘love’s labour’ (Kittay 1999) – leading to grudging consent with the reformed rules.
The helping hand of citizen-carers: a utopia?

Both care recipients and family care-givers thus feel trapped between the new morality of ‘active’ citizenship and their privately held beliefs about the ‘right’ way to depend formed during a period of welfare state expansion (Hochschild 2013). But what about the promise of the Wmo to revive the ‘spirit of community’ (Etzioni 1993) and engage all citizens in the meaningful exchange of care (Jager-Vreugdenhil 2012)? How do care recipients and family care-givers judge the (possible) contributions of their fellow citizens?

This thesis found that they do not experience society to be ‘caring’. They instead experience the weight of the reforms landing on their shoulders. Disabled citizens and their families describe the Wmo ideal of a caring society as a utopia given the conflicting demands of the ‘workfare state’ where paid work comes first (Peck 2001). Care recipients perceive voluntary care as an informal agreement on which they cannot rely for their long-term needs. The volunteer may become bored, fed up or disinterested and end the agreement at any time. Over time, disabled and elderly persons did experiment with voluntary support to aid their social participation, but they often felt misrecognized by volunteers who misjudged their (dis)abilities, or when contacts stranded sooner than they had hoped. Relying on volunteers thus often undermined their self-esteem. In the eyes of family care-givers, care-sharing with anonymous volunteers was often perceived as a threat to the safety and well-being of their loved ones. In contrast to the faith they had in care-sharing with professionals, they mistrusted the motives of fellow citizens willing to care ‘for free’. And as they watched their neighbours rush back and forth from work, they wondered who would have the devotion and patience to care for their disabled or chronically ill relatives. To safeguard the quality of care, family care-givers did not share their duties with unknown others. As trust is the ‘oil in the wheel of care’ (Sevnhuïjsen 2004), scepticism over voluntary care will likely continue.

The ambiguous success of ‘active’ citizenship

The current Dutch care reform agenda aims to morally revitalize society. Nevertheless, official evaluations of the reforms rarely consider the subjective experiences of affected citizens, who view mounting informal care dependencies
as a moral dilemma rather than a moral revival. The Minister of Health, Welfare and Sport lauds the successes of the ‘AWBZ pakketmaatregel’:

'The introduction of the AWBZ measure in 2009 has led to fewer people who use support with daily activities. Thus the measure has had the intended effect. Support with daily living is now limited to people with moderate or severe restrictions to their self-reliance. The support with social participation has stopped. Although the effects of the measures for the individual client may be annoying, the Minister notes that great social unrest was absent.' (VWS 2010)

Although the findings of this study are not representative for all clients and care-givers affected by the Dutch care reform agenda, they clearly show that the absence of ‘great social unrest’ cannot be equated with citizen consent. Many care recipients and their families experience social and/or emotional costs that go beyond merely ‘annoying’, far from leading to ‘opportunities to take matters into their own hands and shape their own lives’ (VWS 2009: 2). Such a positive framing of the effects of reform not only fails to recognise ‘individual’ social and emotional costs; it also conceals the factors that inhibit individual and collective protest.

**Missing voices in long-term care reform**

Individuals whose entitlements to publicly funded care were cut or reduced have the right to appeal against the reassessment. But most interviewed clients did not use this opportunity, not due to practical obstacles but because they did not want to consume services at the expense of those who ‘really need it’. Many also felt that using their right to appeal was akin to ‘begging’ – an act which would undermine their autonomous identity. For these reasons, care recipients and their families were too ‘ashamed’ to appeal, despite their grievances and the possible inaccuracy of the reassessment (conducted over the telephone). These findings correspond with earlier studies on the de-mobilising effects of (the fear of) shame on protest and complaint (Flam 2005; Aronson 2006). Shame functions as a self-control mechanism; we feel shame when we ‘fail to live up to our own and/or internalized societal standards’ (Flam 2005: 22). It can be ‘triggered in us by others who want to achieve our compliance’ (ibid.); it is a
sanctioning emotion that inhibits unruly behaviour, thoughts or feelings (Scheff 1988). Given the role of shame in inhibiting complaint, the lodging of an appeal did not necessarily reflect the severity of need, but who was best able to surmount (the fear of) shame. Interviewees also did not return to the local authorities with new care requests as they saw this route as a ‘dead end’. Citizens who disagreed with the new rules were thus not only silenced by the care authorities; they also silenced themselves to avoid (the threat of) shame (Aronson 2006; Aronson & Neysmith 1997).

No public demonstrations were held to protest against the ‘AWBZ-pakketmaatregel’ or tightened customary care norm (except for a legal challenge regarding the extension of the customary care norm, described in Chapter 2). Although public protest against long-term care reform was beyond the scope of this study, the existing literature points to at least two factors that might explain the lack of ‘great social unrest’. First, protest is precarious for people who depend on the solidarity underlying collective care schemes as one risks breaching the social contract (Shakespeare 1993). Although the public is generally sympathetic to disabled and chronically ill persons, radicalism will eventually alienate the public support on which they rely (ibid). Second, joining public demonstrations or going on strike is difficult for care-givers: ‘in order to assert their power, they must not give care. In so doing, they undermine their own legitimacy and standing as care-givers’ (Tronto 1993: 143). Especially those who care for close relatives will not easily display their refusal to perform mounting care tasks in public.

In short, the Dutch government views reforms such as the ‘AWBZ-pakketmaatregel’ to have been successful in promoting greater citizen self-sufficiency. It points to the ‘lack of great social unrest’, the ‘reduced number of welfare recipients’ and the (hypothetical) ‘opportunities’ for civic engagement offered by welfare state retrenchment. But in practice, affected citizens face moral and emotional hurdles to appealing against the cuts and participating in public protest. In evaluating the success of the Dutch reform agenda, their missing voices cannot be equated with consent.
Deepening inequities of sacrifice

Individual problems resulting from the cuts are framed as shared sacrifices for the greater good – to preserve public care for ‘those who really need it’. But such claims about fairness and shared sacrifice are ‘merely rhetorical’ (Clarke & Newman 2012: 314). The current Dutch reform strategy is leading to a deepening inequity of sacrifice in at least three ways, thereby ‘making the claim that “we are all in this together” implausible’ (ibid.: 314).

First, the increased ‘tailor-made’ approach to care entitlements assumes that responding to needs on a case-by-case basis (cf. ‘creative justice’, see Foster 1983) is more ‘just’ than granting citizens uniform rights. An often-invoked image is that of the ‘unused wheelchair’: why invest resources where they are not needed? By replacing absolute with negotiable claims, care is said to be more tailored to individual needs, while ruling out unjust claims. As citizens no longer have fixed rights under the Wmo, ‘the welfare recipient must persuade officials of the need for assistance’ (Cox 1998: 11). They must be resolute in conveying that their needs cannot be met through private means. It is likely that ‘the brazen fare better than the meek in such a welfare state’ (ibid.). Socio-economic inequalities will thus increase as individuals and groups better equipped to assert their needs claim a larger share of the (shrinking) welfare pie.

The more selective rationing of care entitlements leads to prioritizing medical and bodily over social and domestic care needs. While the former remain fixed rights within the ‘core AWBZ’, the latter are increasingly seen as private responsibilities. Schuyt (2013) argues that this can be seen as a necessary differentiation between ‘needs’ and ‘wants’. If a need is unmet this leads to ‘panic, urgency and often impotence. If a want is unmet, that is tedious and frustrating, but one can adjust one’s wants to that which is available’ (Schuyt 2013: 11). But alongside the finding that social care needs are not easily adapted to the care that is available, the emphasis on safeguarding medical care while jettisoning public responsibility for social care suggests that the latter is ‘less important’. This is a problematic assumption as the boundaries between ‘needs’ and ‘wants’ are in reality diffuse. For example, a 91-year old interviewee whose weekly access to elderly day-care was discontinued felt as if society had ‘written her off’. The loss of day-care deeply affected her quality of life, and ultimately, her will to live. To only focus on safeguarding bodily care can thus have
inhumane consequences. A too strict separation of (urgent) medical and (less urgent) social care needs also strengthens the dominance of the medical profession in defining the needs of the vulnerable (Hutschemaekers & Tiemens 2006).

Second, the demand for active solidarity interacts with existing gender, race and class divisions in care work (Trappenburg 2009; Tronto 1993). While the rhetoric asserts that all citizens should become active citizen-carers, the reality is that care work is often ‘devalued, underpaid, and disproportionately occupied by the relatively powerless in society’ (Tronto 1993: 113). The appeal for active citizenship thus does not fall equally upon citizens. ‘Those of limited economic means are forced to accept their obligations, while those with extensive resources can purchase exemptions’ (Cox 1998: 12). While at first sight this may seem a fair rearrangement of ‘active’ and ‘passive’ forms of solidarity, it risks deepening existing socio-economic inequalities. Citizens who take on the bulk of informal care-giving not only face losses of income but are also deprived of certain social rights (e.g. pension rights) without paid employment (Knijn & Kremer 1997). The ‘cost of caring’ ultimately puts informal care-givers at risk of poverty (ibid.; Folbre 2012). Although the Dutch government has policies to bridge the competing demands of care-giving and paid employment, the rights of citizen-carers are still secondary to those of citizen-workers (Knijn & Kremer 1997; Lister 2002).

In terms of recognition, care as work is devalued when care-giving is disguised in society (Tronto 1993). In Western society, where care is typically performed by women and servants, the ‘best off members of society often use their positions of superiority to pass caring work off to others’ (Tronto 1993: 113). Care work then often becomes invisible, appreciated only for its instrumental value: personal services to a director are more highly valued than caring for dependents, i.e. ‘those members of society who by normal social standards are unable to care for themselves’ (Waerness 1996: 235). The low status of care-giving means that exemption from it becomes a ‘privileged irresponsibility’ (Tronto 1993). Though the participative discourse praises lay care-givers as the ‘new gold’ in society who ‘exemplify active citizenship’ (VWS 2007: 1), this is ‘lip service’ (Lister 2001: 100). While local authorities ‘compliment’ informal care-givers with symbolic gestures (prizes, dinner parties, etc.), such gestures are mere palliatives when active citizen-carers come to
realize that they are unsupported by fellow citizens who maintain their ‘privileged irresponsibility’.

While the Dutch government claims that the reserving of care for those who ‘really need it’ constitutes equity of sacrifice, in practice the reforms risk deepening existing inequalities between assertive and non-assertive care recipients, higher and lower income groups, and given the gendered nature of care-giving, between men and women. Alongside the socio-economic inequalities resulting from the care reform agenda, reduced recognition for (social) care needs and care as work ‘eats into respect’ as longing for what one lacks breeds a sense of inferiority (Sennett 2003: 117). Or as Sandel (2010: 261) puts it, social justice is ‘not only about the right way to distribute things. It is also about the right way to value things.’ Knijn and Kremer (1997: 349) argue that the central question in care reform is ‘whether welfare states recognize explicitly citizen’s rights to receive or give care’. Under the current care reform agenda, it does neither: care recipients face reduced care rights, while care-givers are saddled with mounting care tasks as ‘second-class citizens’ (ibid.).

The ‘active’ welfare state: romantic authoritarianism

Given the moral traps and deepening inequities of sacrifice faced by citizens affected by cuts to publicly financed care, one may question what kind of government is steering our society (Osborne & Gaebler 1992; Denhardt & Denhardt 2000). Over the past years, governments have experimented with new forms of governance considered better able to respond to uncertainty and the ‘new’ social risks (Beck 1992; Giddens 1999; Taylor-Gooby 2004). The new ‘steering rather than rowing’ role for government entails replacing top-down ‘government’ with collaborative ‘governance’ between the state and its citizens (Rummery 2006; Newman et al. 2004). The participative discourse exemplifies this turn, inviting citizens to act as ‘stakeholders in public service provision, participating in consultation exercises, deliberative forums or citizen panels, taking part in governance arrangements, contributing to evaluation exercises and so on’ (Newman 2011: 115). But how equal is this ‘civic-state partnership’ given the moral compass of the Dutch government in reforming long-term care?

This thesis supports the idea that given how informal care norms are currently enforced, collaborative governance is at best ‘quasi-democratic’
(Newman 2011). By imposing informal care norms upon citizens without sufficiently examining whether they match citizens’ ideas about ‘good care’, the Dutch government is trying to engineer social bonds that do not in reality exist (Trommel 2009; Schnabel 2012). In doing so, the reformed welfare state, rather than taking a step back, is intervening more deeply into the private sphere – most notably into the sphere of the private home (Duyvendak, Knijn & Kremer 2006). The normative principles underlying the Dutch care reform agenda reveal a turn towards the moral – rather than merely contractual – regulation of society (Jordan 2010), a turn that I argue is both romantic and authoritarian.

Romantic, as the ‘community spirit mantra’ only sees the positive side of citizens exchanging care: it minimizes unnecessary medicalization, empowers disabled persons to become independent vis-à-vis the state and to participate in society, contributes to social cohesion, a stable society and democracy (VWS 2007). This romantic view is largely based on nostalgia for the society that preceded the welfare state (Jordan 2010). Bracketing the fact that family (Beck-Gernsheim 1988) and church (Sennett 2003; Hoogenboom 2006) would be difficult to ‘crowd in’ again, the social solidarity underlying the exchange of informal care was not always so rosy. Alongside love and sympathy, there was conflict and relations of unequal power (Tronto 1993: 146).

In many ways, exchanging informal care can be compared to the exchange of ‘gifts’, constituting an ‘economy of gratitude’ (Hochschild 2003; Komter 2003). But gift-giving is not always positive. ‘Gifts reflect, confirm, distort or hurt identities. The motives of gift-giving range from love and sympathy, uncertainty and fear, power and prestige to self-interest and open hostility’ (Komter 2003: 61). When ‘love declines and duty takes over’ in care relations, the darker sides of social solidarity come to the fore (Wilson 1993: 639; Komter & Vollebergh 2002; Komter 2004). For example, care-givers are likely to subordinate their own needs to those of their charges; they can become ‘enraged about their own unmet needs. If they are unable to recognize this rage care-givers are likely to vent their anger on those for whom they care’ (Tronto 1993: 143). Care recipients may also lack the ability to express gratitude and resent or resist (growing) dependency, leading to conflict (Komter 2004). Finally, extended informal care duties fall upon all families – even those where members are at odds or are in the process of separation (CIZ 2013: 60). Rather than being alert to the possibilities for neglect and abuse that arise from vulnerability, the Dutch
government’s view of active citizenship idealizes ‘altruistic’ behaviour (Folbre 2012). A more fundamental discussion of what ‘good care’ entails in families and communities is lacking.

The pursuit of active citizenship is also marked by authoritarianism as its claims are moralising rather than moral (Muehlebach 2007; Clarke & Newman 2012). The demands placed upon citizens are moreover paternalistic; if citizens are inactive in the informal exchange of care, this is attributed to a lack of skills, not of willingness. The Dutch government’s concept of customary care exemplifies this pedagogic citizenship: it treats citizen resistance against the (extended) customary care norm as an ‘educational’ affair. For example, a husband who resists taking over the household when his wife falls ill can look forward to cooking lessons (CIZ 2013). To the extent that citizens are inactive in care-giving, they need to ‘learn’ how to do it. Or as LeGrand (1997) puts is: citizens need to be re-educated in civic virtue, to be converted from self-interested ‘knaves’ into public spirited altruists or ‘knights’. As a matter of principle, citizens cannot reject mounting care responsibilities; that they may do so is not even considered.

The moral authoritarianism of the Dutch authorities can also be seen as instrumental or ‘greedy’ (Trommel 2009). The government summons citizens to become active in the provision of informal care, but only in ways that contribute to the current political project, in effect making citizens ‘executors of government policy’ (Schnabel 2012: 329). For example, municipalities often establish targets for the number of social volunteers they aim to ‘recruit’ within a certain time period. The Municipality of Rotterdam even experimented with contracts where lay care-givers committed themselves to a certain amount of care-giving in exchange for support (Gemeente Rotterdam 2006). The participative discourse thus invites citizens to be active but not activist, implying strategies that ‘open out more of the person to governmental power’ (Newman 2007: 7, 2011; Schnabel 2012). From this viewpoint, devolving care responsibilities to the local level not only seeks to advance the provision of tailored care but is a way to more effectively control citizens’ care-giving behaviour (Mowbray 2010).

While the government’s plea for a caring society seems romantic, the radical enforcement of mounting informal care duties without citizen consent typifies the turn to moral authoritarianism. This thesis has shown that the participative
Discourse effectively generates ‘disaffected’ consent (see Clarke & Newman 2012). Although citizens do not, or only grudgingly, agree with the care reform agenda, the (threat of) shame of dependence and disloyalty to the new social contract hampers activism. While the absence of ‘great social unrest’ may allow the government to pursue further cutbacks to publicly financed long-term care, there is no guarantee that we are heading towards a ‘caring society’. The shame of dependence in the active citizenship discourse may in fact strengthen citizen resentment and/or resistance against growing care dependencies in the private realm.

The coupling of dependence and shame

In ‘active’ welfare states, dependence is increasingly associated with a lack of self-responsibility and moral failure (Fraser & Gordon 1994; Lister 2001). Dependence has been made to appear shameful to delegitimize the ‘passive’ consumption of welfare benefits, while those ‘identified as dependent are assumed actively to seek to reverse this status’ (Fine & Glendinning 2005: 605; Sennett 2003). While the turn towards ‘active citizenship’ may have pushed the unemployed to enrol in welfare-to-work programs, emphasizing the shame of dependency in the field of care may in fact risk undermining people’s self-reliance vis-à-vis the state.

First, restricting publicly financed care to the most severely disabled citizens increases the (threat of) shame of demanding (too) much from the welfare state. In public discourse, citizens become ‘welfare queens’ if they (still) claim public care for their ‘less urgent’ needs. The discrediting of payment for informal care via the personal budget illustrates how a practice previously considered legitimate has now become shameful. Citizens who fall short of the active citizenship ideal may also be viewed as ‘welfare paupers’ when they turn to the safety net of public care. For example, the prioritization of informal care in local assessment procedures presents applicants with an almost existential dilemma: ‘is there no one in your network who cares for you? There must be someone?’ The emphasis on self-responsibility can thus ‘easily lead both to the fear of stigmatization on the part of (potential) claimants, and to stigmatizing and discrediting elements in the practice of administration’ (Van Oorschot 1991: 17). In all likelihood, the appeal to active citizenship not only inhibits requests
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for public care from citizens who can do without it, but also from those who cannot but think they should.

Second, and perhaps more puzzling, is that the Dutch reform agenda’s embrace of informal care emphasizes the need for reduced dependence and promoting ‘personal strength’ (eigen kracht), ‘self-empowerment’ (zelfredzaamheid) and ‘self-control’ (zelfregie). The policy rhetoric presents autonomy as an absolute value for being a respectable citizen (Duyvendak 1999; Sennett 2003). As such, it upholds the ‘myth of autonomy’ (Fineman 2004) wherein all dependence is suspect. But the completely independent citizen is ‘a virtual, non-existent human being’ (Knijn & Kremer 1997: 352). Rather than alleviating dependence on care, the current reform agenda risks increasing the shame of depending on care. The shame of dependence also comes back to haunt the private sphere, where it pressures care recipients to uphold an image of their own autonomy in the eyes of their friends, neighbours and even close relatives. Care recipients then feel they must perform deep acting to suppress feelings of dependence and/or resist (extended) informal care altogether. Family care-givers also suffer from this negative image of dependence as it locates care within ‘trivial, private and emotional states’ thereby ignoring its broader social, moral and political significance (Tronto 1993: 112; Waerness 1996).

The Dutch reform agenda with its call for self-reliance thus emphasizes the shameful side of depending on public services while denying the reality of dependence in the private realm. The key question is what makes it so difficult to accept that dependence is the ‘ultimate characteristic of every individual human being?’ (Knijn & Kremer 1997: 352; see also Fine and Glendinning 2005; Tronto 1993). Sennett (2003) argues that the shame of dependence is rooted in the ‘infantilization thesis’: ‘liberal thinkers have supposed that dependency, particularly dependence on government, makes adults behave like children’. Independence is equated with adulthood and maturity; dependence with childhood and immaturity. These negative associations of dependence have profoundly shaped modern beliefs about respect and esteem. To move towards a more caring society, the dignity of dependence needs to be affirmed (Tronto 1993; Sennett 2003).
The dignity of dependence

In Western societies – and especially in reformed, ‘active’ welfare states – the shame of dependence arises from ideals of adulthood and rational self-sovereignty. This coupling of shame and dependence is culture-specific and it is ‘useful to keep in mind just how culturally specific’ it is (Sennett 2003: 114). The same connection between shame and dependence does not necessarily arise in other cultures. For example, in Japan, the verb *amaeru* denotes a specific kind of relationship, ‘to depend and presume upon another’s benevolence’ (Doi 1986: 121). According to Doi, the author of *The Anatomy of Dependence* (1986), the term equates dependence with ‘closeness’ and idealizes the parent-child bond as the most valued one in society. When a person becomes an adult, dependence upon another’s benevolence does not become shameful. Put differently, ‘each moment of surrender creates an immediate connection to people who don’t know one other’ – it ties people together (Sennett 2003: 115). Shame ‘comes to the person who fails to respond, shame comes to the indifferent individual’ (Sennett 2003: 115). Doi agrees that the desire to entrust another with one’s dependence is not an emotion limited to Japanese culture, though the fact that no exact equivalents to *amaeru* exist in other languages suggests that other societies may find it more difficult to be attentive to the positive emotions and feelings of dependence (Doi 1981, 1986; Milkov 2009).

This cultural comparison suggests that to move towards shame-free dependence, we need to value *interdependence* as a common human trait – one which allows us to ‘understand both autonomous and involved elements of human life’ (Tronto 1993: 162). But arriving at shame-free dependence will require a fundamental shift in our political and moral thought. First, we need to accept that autonomy only comes after a long period of dependence and that to some extent, we remain dependent on others throughout our lives (ibid.). Second, dependence should not be seen as an immoral state to be surmounted, but valued for its ability to establish ties between people (Knijn & Kremer 1997; Fine & Glendinning 2005). Third, we need to accept that autonomy cannot be understood as the ‘capacity to separate from others’ or as non-dependence (Sennett 2003: 120; Fine & Glendinning 2005), but at most, as the freedom to choose between one’s *spheres of dependence* (cf. decisional autonomy, see Collopy 1988; or relational autonomy, see Mackenzie & Stoljar 2000). Finally, shame-
free dependence requires that those who depend on another’s benevolence are treated with respect. The ‘autonomy’ granted to a care recipient should be equal to that of the care-giver: ‘to avoid the virtuoso’s mastery, the grant must be mutual’ – even if we do not understand the other (Sennett 2003: 122). These are all necessary ingredients for dependency to become dignified, in both the public and private realms.

In emphasizing the dignity of dependence – or interdependence – we need to be wary of constructing dichotomies between care and social justice (Tronto 1993; Barnes 2006, 2012) and obscuring the ‘underlying unequal relationships of dependence and independence’ in policy discourse that uncritically uses the language of interdependence (Lister 1997: 21). Fraser and Gordon (1994: 24) point to an important difference between two kinds of dependence: whereas ‘socially necessary’ dependence is rooted in the basic human trait of needing care, ‘surplus’ dependence is rooted in fundamental social injustices related to e.g. gender, race and class (see also Tronto 1993). In valuing interdependence, these unequal power relationships within the exchange of care should not be overlooked or justified. Dependence cannot become dignified if interdependence becomes a vehicle for welfare state reform to jettison public care responsibilities while simultaneously deepening structural social inequalities. Moving towards a truly ‘caring society’ can only succeed if we are really ‘all in this together’.

Notes

1 A typical example was the Dutch life course insurance which encouraged individual savings for care leave, parental leave and retirement (see Knijn 2003).
2 Dutch: keukentafelgesprek.
3 Commodification refers to the process in which goods and services that are not yet market ‘commodities’ become connected to the cash economy (Esping-Andersen 1990).
4 Or moving back to a situation of ‘pre-commodification’ (Esping-Andersen 1990).
5 This is also due to the failure of experiments with the marketisation of care (Newman & Tonkens 2011).
6 Current government plans also entail placing personal care (e.g. dressing, washing, preparing meals) under the Wmo by 2015, meaning there may no longer be rights to personal care.
7 Dutch: zelfredzaamheid / eigen kracht.
8 Referring to the societal value of their care-giving.
Two public demonstrations in The Hague protested against the abolition of the personal budget (23 June 2011) and the cumulative effects of welfare state cutbacks on disabled and elderly persons (19 September 2011).

See e.g. Nico de Boer’s statement that ‘you have five to twenty per cent of citizens who cannot perform self-control … Caring for them cannot be left to volunteers, because it is too important.’ In ZorgWelzijn, 31 May 2012, www.zorgwelzijn.nl/welzijnswerk/nieuws/2011/5/Nico-de-Boer-Aan-de-welzijnsinstelling-als-supermarkt-komt-een-eind-ZWZ017099W/.

For example, by making existing care leave entitlements and working hours more flexible (VWS 2011).

The latest government plans require municipalities to recognize informal care. They ‘will be required to record how the college in their regulation of mayor and aldermen ensures a token of appreciation’ (VWS 2013b: 8).

Paralleling the move from formal to moral citizenship (Schinkel 2008).

Cf. A British guide for local authorities promotes teaching skills as contributing to ‘effective citizenship’ (Newman 2011: 116).

Newly introduced terms such as ‘samenzijn’ (mutual strength) (VNG 2012) and ‘samenzijn’ (mutual empowerment) (Murawski 2013) admit to this need of identifying dependence as dignified.

References


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