

Squeezed out: Experienced precariousness of self-employed care workers in residential long-term care, from an intersectional perspective

Saskia Elise Duijs^{1,2}  | Tineke Abma^{3,4}  | Olivia Plak¹ | Usha Jhingori¹ |
Yvonne Abena-Jaspers¹ | Naziha Senoussi¹ | Casper Mazurel¹ | Zohra Bourik^{1,2} |
Petra Verdonk^{1,2} 

¹Department of Ethics, Law and Humanities, Amsterdam UMC, Amsterdam, The Netherlands

²Amsterdam Public Health Research Institute, Amsterdam, The Netherlands

³Leyden Academy on Ageing and Vitality, Leiden, The Netherlands

⁴Leiden University Medical Centre, Leiden, The Netherlands

Correspondence

Saskia Elise Duijs, Department of Ethics, Law and Humanities, Amsterdam UMC, Amsterdam, The Netherlands.
Email: s.duijs@amsterdamumc.nl

Funding information

ZonMw, Grant/Award Number: 849200012

Abstract

Aim: To understand self-employed long-term-care workers' experiences of precariousness, and to unravel how their experiences are shaped at the intersection of gender, class, race, migration and age.

Background: In the Netherlands, increasing numbers of nurses and nursing aides in long-term care (LTC) opt for self-employment. Societal organizations and policy makers express concerns about this development, as self-employment is seen as a risk factor for poor health. Self-employment is not necessarily precarious work but can contribute to the precariousness of specific groups. Knowledge about inequities among self-employed nurses and nursing aides in long-term care is lacking.

Design: A participatory, qualitative interview study. The research team consisted of four academic researchers and five (un)paid care workers.

Methods: Semi-structured interviews with 23 self-employed nurses and nursing aides in LTC (2019–2020). Data were analysed from an intersectional perspective.

Results: First, we describe that feeling precarious as a hired employee—due to increasing workloads, health risks, poverty and discrimination—shapes care workers' choice for self-employment. Second, we describe inequities between self-employed care workers who could (financially) afford to turn to self-employment as a health strategy and those who felt squeezed out of the organizations due to poverty or discrimination. They more often dealt with precarious work in the context of precarious lives, negatively impacting their health. Third, we describe how negotiating an entrepreneurial identity with a caring identity required material sacrifices and thus contributed to self-employed care workers' financial precariousness, particularly as women.

Conclusion: Our findings indicate that working in LTC is becoming increasingly precarious for all care workers, both for hired and self-employed, with younger, lower-paid and racialized women with unpaid caring responsibilities seemingly most at risk for precariousness.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *Journal of Advanced Nursing* published by John Wiley & Sons Ltd.

Impact: Our findings urge policy makers and care organizations to develop gender and diversity-sensitive policy responses to address these inequities.

KEYWORDS

entrepreneurship, gender, intersectionality, long-term-care, nurses, nursing aides, occupational health, precariousness, racism, self-employment

1 | INTRODUCTION

Healthcare workers, such as nurses and nursing aides, care for the health and well-being of individuals, families and communities. Yet, while caring for others their own health might be compromised. In the Netherlands, a postwelfare state that deals with an ageing society, care workers have to attend to increasing care loads with decreasing financial means (Maarse & Jeurissen, 2016). The impact hereof is strongly felt in the long-term care (LTC) sector, which deals with the highest sickness-absence leave and turnover rates of the entire care sector (Ministry of Health, Welfare and Sport, 2020). The Dutch situation is comparable to other European countries that aim to constrain health care expenditures through health care reforms, particularly in LTC. In Western-European countries with an ageing society, tensions arise between the financial sustainability of LTC, the health of paid care workers, and societal support for the policy measures (WRR, 2021). The health of healthcare workers is under pressure, but not for all care workers alike. To understand inequities among LTC workers, we need to unravel the intersecting social determinants of health that shape the health and well-being of care workers in LTC.

In the slipstream of these policy transitions, more and more low-paid care workers in LTC opt for self-employment (Ministry of Health Welfare and Sports, 2020). In the health and social care sector, the number of self-employed workers has grown from 73,700 to 128,600 between 2007 and 2018 (Central Bureau for Statistics, 2020). Numbers continue to grow. In 2022, the number of self-employed care workers further increased to 168,439 (The Netherlands Chamber of Commerce, 2022). Self-employment is used to predominantly attract higher-paid professionals, such as nurses and doctors (Conen & Schippers, 2019). Nowadays, lower-paid professionals, such as nursing aides, make up a large amount of self-employed care workers (Central Bureau for Statistics, 2020). As a consequence, sectors that employ mainly low-paid care workers, such as residential LTC for older people, are increasingly confronted with self-employed care workers. For them, this is a relatively new phenomenon and the LTC sector struggles with this development (Jakobsen et al., 2021).

What is happening in the LTC sector reflects labour market tendencies on a national level. Self-employment is increasingly becoming relatively common in the Netherlands, compared to other European countries (Central Bureau for Statistics, n.d.) and this growth affects almost all sectors of the labour market (CBS, 2020). The Dutch situation does not stand alone, as the flexibilization of labour markets is a

worldwide phenomenon (Kalleberg & Vallas, 2017), but particularly profound in countries that have fostered neoliberal policies in the last decades (Stanford, 2017).

On a societal level, politicians and policy makers debate the desirability of self-employed care work (Ministry of Health Welfare and Sports, 2020). Societal organizations and public health researchers express concerns about the precariousness of self-employed care workers in the Netherlands (Bodin et al., 2020; Julià et al., 2017; Ministry of Health Welfare and Sports, 2020). Most self-employed care workers do not have social insurance such as retirement pensions and only a small minority (17.8%) has disability insurance (Ministry of Health, Welfare and Sport, 2020). Overall, self-employed workers face a relatively high risk to fall below the poverty line, and this risk appears to be substantially higher for women and racialized groups when self-employed (CBS, 2019). Lorey (2015) conceptualizes precariousness as the lived and subjective experience of being in a socially vulnerable or precarious position. Thus, self-employment is not necessarily precarious but can be experienced as precarious by specific groups of care workers (Conen & Schippers, 2019; Wall, 2015). Yet, little is known about the experiences of self-employed care workers in LTC: who experiences self-employment as precariousness and who does not – and why (Wall, 2015).

2 | BACKGROUND

In the field of health research, much scholarship revolves around precarious employment and whether or not self-employment is precarious work (Conen & Schippers, 2019; Kalleberg & Vallas, 2017; Kreshpaj et al., 2020). Precarious employment is defined as a combination of employment insecurity, income (in)adequacy and lack of rights and protection (Kreshpaj et al., 2020). From a public health perspective, scholars increasingly recognize precarious work as a risk factor for health, impacting the physical and mental health of workers and their families (i.e. causation) (Bodin et al., 2020; Julià et al., 2017). And vice versa, people with health problems more often work under precarious conditions (i.e., selection). Generally, scholars identify three links between precarious work and health (Bodin et al., 2020; Julià et al., 2017). First, experiences of uncertainty, unfairness and powerlessness impact workers psychological and physical health. Second, workers in precarious work disproportionately face detrimental physical and psychosocial working conditions; more often deal with discrimination and stigmatization at the

workplace, and; lack access to occupational health care. Third, the material deprivation and lack of access to social security contribute to socioeconomic health inequities.

Other scholars argue that the (health) impact of precarious work cannot be understood in isolation from societal context, foregrounding the concept of *precarization* (Porta et al., 2015; Syed, 2020; Berg, 2021; Lorey, 2015). Precarization refers to the governmental policies by which increasing numbers of people are confronted with precariousness, not only in the labour market but also in all aspects in their lives, including housing and social security. This perspective helps to understand why some workers can mitigate the impact of precarious work in their lives, while others cannot.

Yet, societal debates tend to discuss self-employed care workers as a homogeneous group (Ministry of Health Welfare and Sports, 2020; Commissie Reguleren van Werk, 2020). This is reproduced by studies among self-employed care workers that do not take intragroup diversity into account (Jakobsen et al., 2021; Burke, 2015). As a consequence, policymakers respond to increasing numbers of self-employed care workers with one-size-fits all policy measures (Burke, 2015; Commissie Reguleren van Werk, 2020; Ministry of Health Welfare and Sports, 2020). In general, such policies bear the risk of exacerbating inequities, as they tend to underserve those who are most at risk for marginalization (Hankivsky, 2012).

Therefore, we are in need of more *diversity responsive* research on self-employment of care workers (Burke, 2015; Karatas-Ozkan, 2018). To date, much insightful academic work on self-employment, mostly across employment sectors, has been done from a gender-first or gender-only perspective (McAdam, 2013; Vosko & Zukewich, 2006). Researchers are increasingly adopting an intersectional approach to understand inequities among (self-employed) women (Knight, 2016; Ozasir-Kacar & Essers, 2019; Tao et al., 2021). Also, in the field of occupational health, scholars describe the need for intersectional analytical approaches to understand the complexities of precarious employment, particularly its relation to health (Bodin et al., 2020).

Intersectionality is grounded in a rich tradition of black, queer feminist thought (The Combahee River Collective, 1977). An intersectional perspective aims to understand interactions between social determinants of health, such as gender, class, racialization and age, rather than focusing on single-axe analyses that fail to account for intragroup diversity (Crenshaw, 1990; Hankivsky, 2012). Intersectionality aims to unravel how people's lived experiences are shaped by the interaction of social determinants of health—and also addresses interconnected systems of power that produce privilege or oppression, such as patriarchy, racism, ableism, homophobia or colonialism (Hankivsky, 2012). Intersectionality helps to understand health and labour market inequities, *within* and *between* groups (McCall, 2005). Such a perspective also enables scholars to understand which groups do *not* profit from current policies, because their experience is shaped at a specific, overlooked, intersection (Purdie-Vaughns & Eibach, 2008).

3 | THE STUDY

3.1 | Aim

To understand self-employed care workers' experiences of precariousness in relation to health, we conducted a qualitative interview study (Green & Thorogood, 2018). Our qualitative interview study is in line with a qualitative descriptive study as described by Sandelowski (2000, 2010). This study was conducted with a team of academic researchers and nursing aides, who participated in all phases of the research process (Abma et al., 2019; Wright et al., 2018). We employed an intersectional perspective to understand which (groups of) self-employed care workers are specifically at risk for precarization and why. Such knowledge enables policy makers and health care organizations to develop diversity-sensitive policies for self-employed care workers who are currently underserved by existing policy measures. We formulated the following research question:

How do self-employed care workers in the residential LTC sector for older people experience precariousness, in relation to health and how is their experience shaped by intersecting factors of gender, class, migration, racialization and age/life phase?

3.2 | Design

This qualitative interview study was part of a broader participatory health research (PHR) project 'Negotiating Health' (2018–2022) into the health of care workers in residential LTC. The aim of this parent study was to explore how the health and well-being of paid care workers were shaped by gender in intersection with class, race age/life phase, sexuality and (dis)ability, particularly in the light of recent policy transitions and women's overrepresentation in paid care work.

PHR is part of the family of transformative and action-oriented research practices, such as action research or community-based participatory research (Abma et al., 2019; Mertens, 2008; Wallerstein & Duran, 2017). PHR is conducted in the field of health research and aims to 'maximize participation of those whose life or work is subject to the study in all phases of the research process' (Wright et al., 2018). Therefore, this PHR project was conducted by a team of four academic researchers (Duijs, Bourik, Abma and Verdonk) and five community researchers (Plak, Jhingori, Senoussi, Abena-Jaspers and Mazurel) who are experiential experts as paid and unpaid care workers in LTC. Three community researchers worked as (advanced) nursing aide, one as a nurse assistant and one as unpaid caregiver in LTC. PHR is characterized by moral dilemmas and power imbalances. A methodological reflection of our participatory research process is described elsewhere (Duijs et al., 2022).

In the parent study, we conducted several qualitative interview (sub-) studies among hired employees, and among men and women working in LTC, before and during the COVID-19 pandemic. This

sub-study particularly focusses on the experiences of *self-employed women* and was conducted in 2019–2020. The consolidated criteria for reporting qualitative research (COREQ) guided the reporting of the study (Tong et al., 2007). Findings from other sub-studies are published elsewhere (Duijs et al., 2021, , submitted; Wees et al., in press).

3.3 | Theory of science

The parent study 'Negotiating Health' was informed by a transformative and participatory research design (Abma et al., 2019; Mertens, 2008; Wallerstein & Duran, 2017), embracing experiential knowledge as essential for academic knowledge production and by doing so fostering epistemic justice in research (Fricker, 2007). PHR and intersectionality are both social-justice-oriented research approaches, grounded in critical theory (Verdonk et al., 2019; Wallerstein & Duran, 2017). In PHR, knowledge is produced in a hermeneutic dialogue between different types of knowledge, including academic theories (such as intersectionality) and experiential knowledge (Duijs et al., 2022; Gadamer, 1960).

In the qualitative interview-study presented in this article, we studied participants' lived and subjective experiences with precariousness, inspired by phenomenology (Denzin & Lincoln, 2011), while not overlooking the material and social circumstances of peoples' lives. In our intersectional analysis of their experiences, the academic research team drew upon critical theory to unravel the societal inequities that shaped their lived experiences.

We understand intersectionality as a normative, methodological and theoretical approach to health research (Hancock, 2007). Intersectionality guided our research question, recruitment, data generation and analysis (Duijs et al., 2022; Hunting, 2014; Stuij et al., 2020).

3.4 | Participants

Participants of this interview study (Table 1) were recruited through organizations (such as the professional associations for nurses and nursing aides, unions, LTC organizations, support organizations for informal caregivers, migrant organizations and the professional association for self-employed care workers), via social media and via the personal network of community researchers. Initially, we focused on self-employed care workers in residential LTC (i.e. nursing homes), but rapidly realized that many worked across different sectors (domiciliary and residential care) and home-dwelling clients. Following our intersectional approach, self-employed care workers (N = 23) were purposively sampled across genders, age, occupational level and cultural background/migrant status (Hunting, 2014). Occupational systems in LTC differ across countries. In the Netherlands, nursing aides (level 2) and advanced nursing aides (level 3, also: certified nursing aides) make up the majority of the LTC workforce and are both low-paid

occupations (Tuinman, 2021; cf. van Wieringen et al., 2022). Based on our first analysis of 10 interviews, we initiated a theoretical sampling (based on intersectionality) to specifically include and explore the perspectives of care workers of colour, single mothers and older women in more depth, as their experiences appeared to be distinctly shaped. In Table 1, we present care workers self-identified cultural identity. In the interviews, their cultural identity did not emerge as a theme, but participants did emphasize the importance of racialization as a consequence of their skin colour (being seen as 'white' or 'black'), which we describe in our findings.

We included participants until we had sufficient evidence to describe the diversity and inequities among female self-employed care workers and how these played out according to gender, class, ability, age, sexuality and race (i.e., data saturation). Experiences of nursing aides (level 2) remain relatively underrepresented in our sample, due to time constraints (i.e. data saturation did not occur in relation to their experiences).

3.5 | Data generation

Semi-structured interviews were conducted by an academic researcher, sometimes accompanied by a community researcher. The community researchers were could not always join the interviews, due to time constraints or changing work schedules, and later on, due to the COVID-19 pandemic that severely impact their work and lives. In line with our PHR approach, the topic-list for this study was developed with and by the community researchers who identified themes and topics that were relevant to them during a 6-month photovoice project that was conducted prior to this qualitative study (Duijs et al., 2022; Wang & Burris, 1997). Topics included balancing paid and unpaid care work, financial concerns, age-related health issues, such as menopause, and health strategies of care workers while working in LTC. During the photovoice process, the community researchers made a poster displaying these themes, supported by their own photographs. This poster was used during the interviews as a conversation tool and to allow participants to set the agenda using the following question: 'If you look at this poster, is there a theme that resonates with you? What do you think is important to talk about during this interview?' A topic list with open questions was developed to probe on different sub-themes on the poster. The interviewers were trained in intersectionality and probed on participants' intersectional experiences during the interview (Hunting, 2014).

Face-to-face interviews were conducted across the Netherlands, between May 2019 and March 2020, and by telephone from March 2020 to May 2020 when the COVID-19 pandemic set in. Interviews lasted between 54 and 118 min, most of them lasted approximately an hour. Interviews were recorded and transcribed ad verbatim. Data was securely stored at the internal drive of Amsterdam University Medical Centre. This study focuses on experiences of self-employed care workers before the pandemic. Interviews were conducted in Dutch and translated by the first author. Member checks were

TABLE 1 Participant characteristics

R	Age	Household	Minority/majority	Profession	Domiciliary residential	Unpaid caring responsibilities	Location interview	Interviewer
R1	42	Married ^a	Dutch Majority	NA (2)	R	Children (2)	Home	SD
R2	50+	Divorced, partner ^a	Dutch Majority	ANA (3)	D	Children ^c (2)	Work	SD
R3	37	Married ^a	Antillean-Dutch	ANA (3) + MSc.	R/D	Children (3), mother (Curacao)	Public location	SD
R4	58	Divorced ^a , Single	Dutch Majority	ANA (3)	R/D	Father ^b	Home	SD
R5	52	Married ^a	Dutch Majority	ANA (3)	R/D	Children ^c (4)	Home	ZB + YJ
R6	50+	Married ^a	Dutch Majority	ANA (3)	R	Children ^c (4), mother	Home	SD + YJ
R7	58	Married ^a	Dutch Majority	ANA (3)	R	Mother, grandchildren (2)	Home	ZB
R8	40	Married ^a	Moroccan-Dutch	NA (2)	R/D	Children (3), 2 with disability	Telephone	ZB
R9	61	Divorced ^a	Dutch Majority	N (4)	R	Children ^c , father	Home	SD + OP
R10	60	Single	Surinamese-Dutch	NA (2)	R	Parents	Public location	SD
R11	36	Single	Antillean-Dutch	ANA (3)	R/D	Children (2), 1 with disability	Home	SD
R12	±30	Single	Cameroon-Dutch	ANA (3)	R/D	Child (1)	Telephone	SD
R13	39	Unknown	Surinamese-Antillean-Dutch	ANA (3)	R	(undisclosed)	Telephone	SD
R14	60	Divorced ^a	Antillean-Dutch	ANA (3)	R	Children ^c , parents	Telephone	SD
R15	70	Married ^a	Dutch Majority	ANA (3)	R/D	Grandchildren	Home	SD
R16	55+	Divorced, re-Married ^a	Dutch Majority	N (5)	R/D	Children ^c , mother ^b	Public location	SD
R17	37	Married ^a	Dutch Majority	N (4)	R/D	Children (2)	Home	ZB
R18	64	Married ^a	Surinamese-Dutch	N (6)	R/D	No	Telephone	SD
R19	33	Single	Surinamese-Dutch	NA (2)	R	Children (2)	Telephone	ZB
R20	30	Married ^a	Moroccan-Dutch	ANA (3)	R	Parents in law, child (1)	Telephone	ZB
R21	50	Partner ^a	Dutch Majority	ANA (3)	R	Parents in law ^b	Telephone	SD
R22	28	Single	Moroccan-Dutch	ANA (3)	R/D	No	Telephone	ZB
R23	58	Single	German-Dutch	NA (2)	R	Children ^c (4)	Telephone	ZB

Abbreviations: ANA, advanced nurse assistant; N, nurse; NA, nurse assistant.

^aHeterosexual.^bPassed away.^cMature children.

conducted by feeding back summaries of the interviews when participants indicated that they would appreciate that, which was done by one participant. Most participants indicated that they rather received a summary of our study findings, which was presented to them in a factsheet.

3.6 | Ethical considerations

This study was evaluated by a Medical Ethical Review Committee which confirmed that the Dutch Medical Research Involving Human Subject Act did not apply. Transcripts were anonymized and audio-tapes and transcripts are stored anonymously and will be archived until 5 years after the completion of the study. Informed consent forms were explained orally and a copy was handed to the participants. Participants signed informed consent forms which are securely stored at Amsterdam University Medical Centre.

3.7 | Data analysis

Data generation and data analysis were done iteratively and collectively. First, data was discussed in monthly—audio recorded and transcribed verbatim—dialogue meetings with the research team, including the community researchers. Newly emerging topics, such as experiences of racism, were added to the topic list. Second, the first author conducted an inductive thematic analysis using MAXQDA, guided by the last author, following a process of open, axial and selective coding (Braun & Clarke, 2006). This coding process yielded several descriptive themes but lacked sensitivity to diversity and inequities among participants. Therefore, third, after the thematic analysis, we (Duijs and Verdonk) applied an intersectional perspective to deepen our understanding of the ways these experiences were shaped at the intersections of gender, class, race, migration status, disability and age (Crenshaw, 1990; Hankivsky, 2012). This intersectional coding process was informed by two practical guides on (secondary) intersectional analysis in qualitative research (Hunting, 2014; Stuij et al., 2020). This analysis enabled a more in-depth understanding about the societal inequalities that became visible in interviewees' experiences. An overview of the themes with intersecting aspects that shaped workers' experience is presented in Table 2. Findings were discussed with the academic research team until we agreed on the themes that are presented in this article. The outcomes from this second and third round of analysis were discussed with the community researchers, who validated our findings. We discussed our analysis with the community researchers, but their participation in this analytical phase was relatively limited when compared to earlier phases of the research process. The community researchers were not involved in the writing of this article, as writing and reading academic articles in English provided too big a barrier for them to participate. However, the findings were discussed with them and they agreed with the content of this article.

3.8 | Rigour

We employed the following strategies to enhance the quality and rigour of our study (Frambach et al., 2013; Green & Thorogood, 2018). The study was conducted with a team of multiple academic and community researchers. Intensive dialogue about the findings contributed to the credibility of our study. At the request of our participants, we conducted member checks on our study findings by sending a summary of preliminary findings and requesting feedback. The maximum variation sampling strategy enhanced the transferability of the findings and supported our aim to do justice to the diversity among our participants. Data generation and analysis were done iteratively and impacted following interviews. We continued until we reached data saturation, which supports the dependability of our findings. Findings were discussed with societal organizations in steering group meetings and in individual conversations with a representative of a professional association for self-employed care workers. Their reflections validated our findings as well, which contributed to the confirmability of our study. But most of all, the input and reflections of the community researchers have contributed greatly to the quality of our study, as their lived experiences guided our attention to themes that otherwise would have remained brushed under the carpet, such as racism, poverty and menopause.

4 | FINDINGS

Participants in this study worked as self-employed nursing aides ($N = 5$), advanced nursing aides ($N = 14$) and nurses ($N = 4$). They ranged from 37 to 70 years of age and consisted of individuals from Dutch majority groups (that is, white women with a Dutch nationality) and Dutch minority groups (that is, who self-identified as bi-cultural and/or as a women of colour). Participant characteristics are described in Table 1.

We describe our empirical findings in four parts. First, we describe how experiences of precariousness as a hired employee within LTC organizations shape care workers' choice for self-employment. Second, we describe how opting for self-employment is shaped by gender, class, race and life phase, illuminating differences among self-employed care workers. In the third section, we describe how self-employed care workers negotiate a 'masculine-typed' entrepreneurial identity with their caring identity as women, which contributes to precariousness, particularly as female self-employed care workers.

4.1 | Theme #1: Opting out: The precariousness of being a hired employee

Participants foregrounded their experience of the precariousness of working within LTC organizations. Many participants experienced working as a hired employee as riskier in terms of health,

TABLE 2 Themes and intersections

Theme	Sub-theme	Sub-subtheme	Intersections
1. Opting out	A care sector under pressure	Devaluation of care work	Gender
		A sense of alienation	Age
		Re-allocation of care responsibilities to lower professional levels	Class
	Health risks	Burn-out	(Dis)ability
		Lack of access to disability insurance	Age class (dis)ability
		Exploitation of one's health	Gender age class (dis)ability
	Poverty and fear of debts	Financial precariousness	Gender age class marital status
		Financial risks of flexible work schedule	Gender age class marital status
		Child benefit scandal	Race
	Informal care responsibilities	Combining paid and unpaid care work	Gender
		Motherhood	Gender age
		Informal care giving to children with a disability	Gender age disability
	Menopausal transition	Transition into a more masculine identity	Gender age
		Becoming older	Gender age
		menopausal complaints	Gender age
	Ageism in the workplace	Work-related health issues	Age (dis)ability
		Less access to career opportunities	Age class (dis)ability
		Everyday racism within care teams	Race
		Institutional racism	Race
2. Inequities among self-employed care workers	Shortages of staff	Labour market privileges for ANA (level 3) c/t to NA (level 2)	Class
	Privileged lives	Pre-pensions	Age class
		Low housing costs/paid-off mortgages	Age
		Heterosexual marriages	Gender marital status sexuality
		Opting out of disability insurances	Gender age class (dis)ability marital status sexuality
		Impact of divorce	Gender class marital status race
	Precarious lives	Precariousness of being a breadwinner on paid care work/poverty	Gender age class marital status race
		Unaffordable housing	Class age
		Working while sick	Gender class (dis)ability marital status
		Racialized inequities	Race class marital status
3. Gendered negotiation acts	Framing work	Distancing from masculine-typed entrepreneurial values "not doing it for the money"	Gender class
	Investing own resources into one's care work	Time	Gender class
		Money	Gender class
		Expertise	Gender class
	Caring identities as a privilege	Silencing and condoning financial motives	Gender class race

finances or well-being, compared to being a self-employed care worker. Others experienced a lack of a healthy psychosocial working environment as a consequence of gender, race and age-related discrimination in LTC organizations. They opted for self-employment to deal with these experiences of discrimination and exclusion. We will illuminate these experiences in more detail below.

4.1.1 | Work pleasure under pressure

All participants framed their choice for self-employment against the backdrop of a care sector under pressure. Older participants expressed a sense of alienation as they witnessed their work change over the years, with increased bureaucratic loads and decreasing time for clients. Some participants even felt increasingly unable to

live up to their own professional and/or personal standards of care as a hired employee, due to recent budget cuts and shortages of staff. Witnessing incidents in which quality of care was compromised urged them to take action:

Right there and then, I decided that I didn't want to be belong to that club anymore. I mean, you can go to a different organization, but it is the same story everywhere. The problem is bigger. So, I literally stepped into my car and drove away. (...) That same afternoon I registered myself as a self-employed. (R21)

4.1.2 | Health risks of being a hired employee

Many participants experienced precariousness in terms of health as a hired employee. For many participants, working in residential LTC came at the expense of their own health and well-being. Several participants opted for self-employment after experiencing a burn-out, or to prevent one. The increased autonomy of self-employment allowed care workers to employ health strategies that were unavailable to them as hired employees. Self-employment also enabled them to disconnect from institutional moral appeals, as it provided the 'emotional distance' necessary to set boundaries.

I: Is it easier to say no as a self-employed? R1: Yes, sometimes. If you are a hired employee then you are constantly asked to fill in shifts. (...) As a self-employed, I just check a (digital) schedule and choose shifts whenever I can, at a location like. I: So, the pressure is less, because you are in charge? R1: Yes, definitely. (R1)

Self-employment was a health strategy, not so much of a choice, rather a necessary evil to sustain, protect and maintain their health. A participant described how she could not afford a disability insurance as the costs were relatively high due to her age and medical history. Yet, she emphasized that the risk of financial adversity as a self-employed felt less precarious compared to the risk of getting ill (again) as a hired employee.

I am convinced I would get sick. In my opinion, the problem is bigger. It feels as if I have no other options left. It is not even a choice to become self-employed. It is a survival strategy. (...) Being self-employed is the best disability insurance I can imagine. (R16)

In addition, several, particularly younger, participants expressed anger and frustration about how austerity measures and budget cuts came at the expense of their health and well-being.

Self-employment can thus also be understood as a protest against these health risks:

You don't earn much and your health is ruined. (...) While at the other hand, there are care organizations making money (...). So, when I think about the future, I know that I cannot do this job for another 20 years; it is just too hard. And if do, I do it for myself. As a self-employed, at least I am the one making some money out of it. (R22)

4.1.3 | Poverty and fear of debts

Many, younger and single women, particularly single mothers, pointed out that they felt at risk of ending up in (financially) precarious situations as a hired employee. They could not make ends meet as a hired employee and used self-employed care work to earn more money. Others described the financial risks of having to be 'flexible' as a hired employee:

A as single mother I am responsible for all our finances. As a self-employed, I can make sure that the costs for my children's daycare are stable. That is a big difference with the time when I was a hired employee. My employer often changed my shifts, required me to work an extra day or cancelled a shift. Then you are confronted with retrospective repayments. (R11)

Her fear for retrospective payments has to be understood in the context of the Dutch tax system in which people receiving childcare allowance are confronted with retrospective repayments if they have worked irregularly, which puts them at risk for indebtedness. This fear was amplified by the recent child benefits scandal in the Netherlands, that unjustly indebted 10,000 of families, particularly those of colour, receiving childcare allowance (House of Representatives, 2020).

4.1.4 | Informal caring responsibilities under pressure

Several female participants opted for self-employment to attend to their informal caring responsibilities, for their parents or grandchildren, for their children or for both. Several younger women experienced troubles combining work and motherhood as hired employee, and turned to self-employment as a solution. Often, human resource policies in LTC organizations require flexibility from hired employees, especially in the context of shortages of staff. As a consequence, many felt pressured to be *available* for work 24/7, without adequate support to organize paid work around informal caring responsibilities:

I have three children and two of them have special needs. Care organizations are simply unable to organize my shifts around their care needs. They would schedule my shifts day and night. I cannot go and request for an exception every time. As a self-employed, I have control over my schedule. (R8)

Attending to unpaid caring responsibility was uniquely challenging for care workers with a migration background. Transnational caring responsibilities required them to travel for longer periods abroad, yet they were not always granted their right for longer holidays as a hired employee:

I've always known, I might be born here, but I am not seen like that. I know I am entitled to six consecutive weeks of holiday, but then my colleagues look at me like: "the summer is the most difficult time in the care sector. What is she thinking? Going on a holiday, not just for three weeks like the most of us, but for four of five." As a self-employed I can just decide how long I go. (R3)

4.1.5 | The role of menopausal transition

Several mid-aged participants connected their choice for self-employment to their experiences as (post-) menopausal women. Menopause-related physical complaints such as fatigue, burn-out or increased weight made their health concerns more pressing. More importantly, several women narrated how menopause induced a more spiritual and psychological process which made them reflect on their lives and work. Some participants described menopausal transition as becoming more 'masculine' as they started to question their caring identities as *women* that required unlimited attention to other people's needs, and they increasingly allowed themselves to foreground their own needs.

You become a little more indifferent. (...) You become a little bit more like a man, they have said to me. Well, maybe it is true. I think at least I started to be more relaxed and confident. I: It was the time you started to address issues at work and decided to opt for self-employment (...) R: Yes, but still, you can never really tell if it was menopause or just all the negative stuff that happened. (R4)

Others linked this process with getting older, and increased trust in their own knowledge and expertise as an experienced care worker. As a consequence, they found it more difficult to fit into hierarchical LTC organizations which appealed to their caring identities, while lacking participation and voice over their working conditions:

Forty was my turning point. At that point I said: I'm done. I want my life to be different. (...) I see that happening around me very often. You are more or less at halfway your lifetime. That's how it feels. And then you look back and think: am I content? Am I enjoying my life? Am I happy? In my case, the answer was: no, no, no. At that point, I realized that things needed to change. And yes, the hormones definitely played a role in that process. (R2)

4.1.6 | Ageism in the workplace

Older participants, in their 60s and, with work-related health issues, shared how they felt treated as a financial risk by their employers, felt pushed into unemployment benefits or early retirement by their superiors, or were denied career opportunities. They turned to self-employment to continue their career as a paid care worker.

I was more or less kicked out because of my age. That's kind of how things started. I really loved my job and I cried because I had to go. And then I found myself sitting at home, knowing that there were shortages of staff. It just tugged at me. And then they asked, why don't you join our team as a self-employed. (R15)

4.1.7 | Racism in the workplace

Participants of colour mentioned experiences of racism in LTC institutions as a key factor that pushed them out of the institutions into self-employment. Remarks, jokes, lack of support or trust from colleagues and managers were experienced as most painful, and played a big role in their decision to opt for self-employment:

The work in itself is hard enough, you know. And then you add colleagues who ... Well, no, I would not go back to being a hired employee, because of this racism thing (R13)

Some participants were hesitant to frame their experiences as experiences of racism and several initially framed it as 'fuzz within the teams' (R12) to the white interviewer of this study (first author). Other participants were very outspoken about the racism that they experienced at the workplace and how it informed their decision. Self-employment provided emotional and practical distance from racism within organizations:

It was the way my colleagues treated me (...) Look, as a self-employed you just do your work, and you don't like it there, you just never go again. (R3)

Lower-educated care workers of colour mentioned how they lacked access to career opportunities as a hired employee. One participant, for example, shared how her white colleagues obstructed her education, which caused her to leave hired employment straight after graduation. Self-employment enabled renewed access to career opportunities, as they could invest in their own education enabled by tax rulings for freelancers.

The organization was all white and they just gave people of color a hard time. Afterwards, one colleague said to me: I am surprised that you managed to get so far. Most people of color don't make it here. (...) The moment I graduated. ... I literally ran to the chamber of commerce. I was so tired of it all. (R13)

In the light of institutional racism in care organizations, for example in organizations where higher-paid managers are predominantly white and lower-paid workers are more often of colour, some participants also expressed how institutional demands for 'flexibility' and 'availability' were laden with colonial history:

In my head the dynamic resonated with colonial history and slavery. There is the master, and here is the slave. I was thinking that I should just create my own job, and bring it to work. To make all of that black-and-white stuff stop. (R10)

4.2 | Theme #2: Inequities between self-employed care workers in terms of precariousness

The experiences of precariousness, particularly in terms of financial security, differed strongly among self-employed care workers. In this section, we describe if, and if so, how participants in our study experienced privilege or precariousness as a consequence of being self-employed. We describe how self-employment can translate into taking health care risks for those without financial buffers.

4.2.1 | Experiencing privilege in the context of shortages of staff

Most participants did not opt for self-employment lightly, and carefully considered the potential precariousness of self-employed work. They referred to current shortages of staff in the sector that would ensure them access to sufficient work. This privilege was felt slightly more strongly by the higher-educated care workers but expressed across different levels. Although some participants referred to major budget-cuts and lay-offs in the (recent) past, they did not expect that this would happen again in the near future.

If you don't have work for a week, then you are in trouble. Well, a week without work? That might have happened a few years back, but that is not happening

anymore. Right now, people are waiting in line for you. I am sure I am able to continue like this until my retirement age. (R7)

4.2.2 | Negotiating 'precarious work' with 'privileged lives'

The older (60+), often white, participants in our study did not perceive self-employment as precarious work. In relation to the first theme, these women were mainly pulled to self-employment to enhance their work pleasure or as a health strategy and could afford to do so. They could fall back on the pre-pensions they built up as a hired employee, or had paid off mortgages over the course of their working lives. Others, relatively younger (40–50), also often white women in a heterosexual marriage, emphasized how they were privileged as they were married to men who held secure jobs. In several occasions, it was these men that motivated them to opt for self-employment in the first place.

I have my husband. He was the one who pushed me into self-employment in the first place. Because, well, he had everything on track, of course (R5)

They perceived self-employment as low-risk, as they could 'afford to get ill'. Their perception of being in a privileged position as women, materialized in opting out for unemployment insurances:

We don't rely on my income for our mortgage. My husband takes care of that. So, in case I would get sick or anything, we don't have to worry a bit. (R7)

Although this was experienced as a privilege, their financial dependency as women was under threat. This was felt by self-employed care workers who opted for self-employment during marriage or a relationship, but lost privilege when they divorced or separated. For them, self-employment became more precarious.

4.2.3 | Negotiating 'precarious work' with 'precarious lives'

Experiences of precariousness were mainly expressed by single self-employed care workers who were breadwinners for themselves or their families. In relation to the first theme, these women were squeezed out of the organizations due to poverty, informal caring responsibilities or experiences of racism. Several younger participants expressed how they negotiated precarious work with precarious lives, for example by pointing towards increasingly unaffordable housing. For single women, being financially responsible as a self-employed care worker translated into health risks. Several participants indicated that they overburdened themselves to save up for difficult times. This participant for example indicated that she continued to work while sick to save up for a period of recovery after an operation:

As self-employed you do feel like to have to work a lot, to make sure that you have a buffer to fall back on. Because, you never know what might happen tomorrow. (R9)

Single mothers who were financially responsible for their families described how they regularly continued to work while sick, and also described how they sacrificed their health for financial reasons:

Only If I have no other option left, then I will call in sick. That is really hard for me. Sometimes at work I do feel like "I shouldn't have done this". But usually, when I am working, I just keep going so you don't feel anything. But when I have a day off, I find myself lying on bed all day doing nothing. That's when I feel it. I can just sleep all day. (R11)

Other self-employed care workers pointed to the structural aspect of this inequality and pointed out that white women were more often in the position to 'afford to get ill', while women of colour less often had access to this privilege:

Well, many white women, they consciously choose for self-employment. Many of them have a husband at home that takes care of everything, and they can just free-wheel as an entrepreneur. They sometimes say to me, I am happy if I can make around a 1000 euros a month as a self-employed. Then I am like, that is a privilege. Because, single women with two children, they do not make it with a 1000 euros a month. You have your children to feed and maybe even family abroad that you need to sustain. That is a different story. (R3).

4.3 | Theme #3: Gendered negotiation acts contributing to precariousness

Many participants struggled to negotiate a 'feminine-typed' caring identity with a 'masculine-typed' entrepreneurial identity. This negotiation act required framing work, and manifested as making financial sacrifices to foreground their caring identity. This negotiating act thus contributed to their precariousness, particularly as female self-employed care workers.

4.3.1 | Framing work: Distancing yourself from entrepreneurial values and foregrounding a caring identity

Self-employed care workers in our study expressed frustration over the way they have been framed in policy documents and mainstream media. In response, several of them explicitly distanced themselves from the idea that care workers choose self-employment

for 'economic' or 'selfish' reasons. In doing so, they distanced themselves from a more 'masculine-typed', profit-oriented, entrepreneurial identity, by foregrounding their caring identity:

'Believe me. I have spoken to a lot of self-employed, and no one says that they are doing it for the money'. (R3)

4.3.2 | Investing own time, money and expertise

A caring identity is performed through making financial sacrifices, such as doing unpaid care work for clients:

Well, if I earn less, then I earn less. If I stay an extra hour, then it is my own time and my own decision. Who cares? It is not costing anybody anything. So, what am I worrying about? It is fine by me. (R2)

Some women invested expertise that exceeded their job description, providing higher quality care for lower tariffs. Others lowered their tariffs, or did not bill all their working hours, out of loyalty to LTC institutions:

I know how it works. So, if I would say, I want to earn a lot of money, I know that someone is paying the price for it. I mean, if a care organization does not want to go bankrupt, it needs to break even. (...) Yes, I feel responsible. I don't need to be paid a high tariff at the expense of someone else. (R16)

As a consequence, participants ended up trading an *exploitative institution* for a system of *self-exploitation*. They opted for self-employment to disconnect from institutional moral appeals, but quickly realized that they were unable to escape their own caring identity.

4.3.3 | Foregrounding a caring identity is a privilege

This was mainly done by self-employed care workers who negotiated precarious work with privileged lives, they could afford to foreground their caring identity. Within this frame, financial motives to opt for self-employment were (implicitly) silenced and sometimes even condoned, reproducing the stigma on those self-employed care workers who opted for self-employment due to poverty or experiences of racism:

There are a few bad seeds who are in it for the money, but they are ruining it for the rest of us. (R5)

5 | DISCUSSION

In our empirical findings, we have described self-employed care workers experiences with precariousness in three themes. In the

first theme, we describe how self-employed care workers experience precariousness as a hired employee due to increasing workloads, health risks, poverty and experiences of (gender, race and age-based) discrimination, and that they negotiate the precariousness of being a hired employee with the precariousness of being self-employed. In the second theme, we describe inequities in precariousness between self-employed care workers who could (financially) afford to turn to self-employment as a health strategy, and those who felt squeezed out of the organizations due to poverty or discrimination and had to deal with precarious work in the context of precarious lives. In the third theme, we describe how self-employed care workers negotiate their feminine-typed *caring identity* with their masculine-typed *entrepreneurial identity*. For women, this negotiation act translates into making financial sacrifices to foreground a caring identity, contributing to their precariousness, particularly as female self-employed care workers. This gendered ideal of “not doing it for the money” was not equally attainable for women who were financially dependent upon their care work.

Our empirical findings resonate with theoretical perspectives on *precarization*. The mere fact that participants in our study experienced being a hired employee as *precarious*, and sometimes even more precarious than being self-employed, illustrates that *precarization* impacts all spheres of the labour market, including the work of hired employees in permanent contracts (van den Berg, 2021; Porta et al., 2015). Our empirical findings show precarious work is to be understood in the context of increasingly precarious lives, resonating with Porta (2015, p.2) who describes that: precarization is not (...) limited to the labour market but can penetrate entire lifeworlds of individuals and groups of people. Our empirical findings illuminate the inequities among self-employed care workers.

Our empirical findings particularly illustrate inequities between self-employed care workers who can afford to turn to self-employment to enhance their work pleasure and health, and those who feel squeezed out of the organizations due to poverty and discrimination. The relatively low financial reward for care work shaped at the intersection of gender and class (Bhattacharya, 2016; SER, 2021) and the fact that care workers opt for self-employment due to poverty is a classed inequity. Experiences with poverty and financial precariousness were more pressing among nursing aides in our study sample, in comparison to the nurses. This might explain why most studies on entrepreneurial nurses pay little attention to financial precariousness (Jakobsen et al., 2021; Neergård, 2020; Wall, 2015). Experiences with financial insecurity also intersected with age. Older care workers described health issues for instance menopausal complaints, age discrimination and lack of career opportunities, which contributed to their precarization as older women in the labour market. In relation to housing, older women more often described that they had the security of paid-off mortgages, while the younger generation struggled with unaffordable housing due to governmental housing market policies (Hochstenbach, 2022).

Studies on women entrepreneurs also describe that those pushed into self-employment tend to be more economically precarious than

those pulled into it (Ahl & Marlow, 2021; Vosko & Zukewich, 2006; Wall, 2015). Yet, literature on the so-called ‘push’ and ‘pull’ hypothesis show that such individual choices for self-employment have to be understood in the context of political and organizational policies, because: “Some pull factors, such as such as independence and flexible working hours may, in fact, reflect the push posed by eroding working conditions and job quality as well as work-family considerations. For example, waged work might be unsuitable because of the lack of child-care, flexible hours or the absence of workplace policies that take into account the responsibilities of workers outside the labor force” (Vosko & Zukewich, 2006, p. 70).

5.1 | The role of gendered policies

In the Netherlands, the LTC sector was confronted with major budget cuts and health policy reforms in 2015. Budget cuts were enacted through two policy acts that aimed to re-allocate caring responsibilities from higher to lower professional levels, and from formal caregivers to informal caregivers (Maarse & Jeurissen, 2016). In the Netherlands, societal organizations have voiced critique on these policy measures, as they would increase gender inequity (Schenk, 2013). These policy measures form the backdrop of our empirical findings, as it impacted care workers *paid* and *unpaid* care work. Paid care workers had to attend to more and more complex caring responsibilities at work. These policy measures also impacted their *unpaid* care work, as female care workers carry a disproportional large amount of informal caring responsibilities at home compared to the entire working population (De Boer, 2017; Schenk, 2013).

In our empirical findings, we recognize that care workers struggle to combine their paid care work with unpaid caring responsibilities as a family caregivers or mother. This resonates with other recent studies that describe how women turn to self-employment as a strategy to resolve their work/life conflict (Bari et al., 2021; Neergård, 2020). Our empirical findings illustrate that these policies indeed contribute to the precariousness of care workers, particularly for those with informal caring responsibilities, such as young mothers and older women who take care of their parents.

5.2 | Gendered ideologies of women's caring identities contribute to precariousness

So, while these policies contribute to women's precarious position on labour market, our empirical findings also show that women are at risk for precarization due to gendered ideologies. Our findings on gendered negotiation acts of self-employed care workers (theme 3) resonate with other studies among self-employed care workers (Anderson & Hughes, 2010; Jakobsen et al., 2021; Nadin, 2007; Neergård, 2020). These studies describe how self-employed care workers, particularly low-paid nurses and nursing aides, are guilting for profit-making, implicating that “doing it for the money” threatens

their caring profession. Nadin (2007) refers to the 'moral precariousness' of building a business on caring, as through the commodification of the caring needs of vulnerable others, they thus risk betraying their own gendered values that construct caring as 'natural and willingly given' (2007, p. 465). Our study adds to these insights by showing how these 'moral' tensions materialize into making financial sacrifices to foreground their caring identities, exposing how these 'gendered ideologies of care' contribute to the *precarization* of self-employed women working in the (long-term) care sector. So, while poverty is a classed/gendered issue squeezing paid care workers into self-employment, gendered ideologies consequently reproduce gender/classed inequity among self-employed care workers.

5.3 | Racism and racialized inequities

In our empirical findings, we illuminate the distinct experiences of women with a migration background, who face specific challenges in regards to transnational caregiving, and those of racialized women who opt for self-employment to escape racism in LTC institutions. We described how younger, single and *racialized* care workers are more likely to experience precariousness as a self-employed care worker, and self-employed care workers themselves emphasized that there is a racialized inequality at play here.

Their analysis is backed up by statistics. In the LTC sector, also in the Netherlands, lower-educated care work is often done by racialized women (Syed, 2020). So, throughout our empirical findings, there is a strong, but often implicit, class/race intersection at play. This class/race intersection often remains hidden as gendered dynamics tend to be more explicit and visible. The fact that racialized women are pushed into self-employment by experiences of racism, is a novel insight from this study. Racialized dynamics tend to stay hidden for white researchers and white policy makers. They are hardly mentioned in political debates and policy papers on labour-market challenges in the LTC sector (Commissie Regulering van Werk, 2020; Ministry of Health, Welfare and Sport, 2020). None of these analyses mention racism as an important issue. Recently, The Black Lives Matter movement in the Netherlands succeeded in getting racism, also in healthcare, on the public and political agenda. Since then, studies have been initiated into care workers experiences with racism. Yet, awareness on racism has yet to trickle down into debates on labour-market dynamics and self-employment.

5.4 | The added value of an intersectional perspective

In our findings, we illuminate self-employed care workers experiences with precariousness. We illuminate the inequities between self-employed care workers, particularly raising attention for the pivotal role informal caring responsibilities, poverty and racism play in *precarization* of particular care workers. These are novel findings of our study. While most studies and policy reports regard

self-employed care workers as a homogenous group, our empirical findings stress that they are not. And popular conclusions about self-employed care work, namely that they are pulled to the freedom of self-employment and are "not doing it for the money" are obscuring the harsh reality that some do, and have to do so in order to sustain themselves and their families. Employing an intersectional perspective helped us to unravel inequities among self-employed care workers and fosters a thorough understanding how their choices are shaped at the intersection of gender, class and race. This enabled us to pay attention to 'intersectional invisible' groups among self-employed care workers who are overlooked by researchers and policy makers (Purdie-Vaughns & Eibach, 2008).

5.5 | Strengths and Limitations

In this study, we included a diverse population that allowed us to understand inequities between self-employed women in LTC. This study did not address the experiences of men working as self-employed care workers, which were distinctly different and were thus described elsewhere (Wees et al., *forthcoming*). Our findings cannot be transferred to all care workers in LTC, as we explicitly aimed to pay attention to particular groups of self-employed care workers that are currently overlooked in studies or policy papers. Our study aimed to explore experiences of low-paid care workers, but our sample consisted for a large part of advanced nursing aides and nurses. This might have caused an underestimation of the inequities among self-employed care workers and the role poverty plays in the choice for self-employment. The experiences of nursing aides and lower-paid colleagues in LTC require more attention, as experiences of poverty among paid care workers is a pressing societal issue in the Netherlands and elsewhere, that has been exacerbated by the COVID-19 pandemic and by increased costs for living due to the current inflation (Duijs et al., 2021).

6 | CONCLUSION

We conclude our discussion by offering suggestions for diversity-sensitive policies that specifically serve self-employed care workers that suffer from this 'intersectional invisibility'. Our findings indicate that self-employed *women* working within the LTC sector, and especially the single, younger, lower educated and racialized women with unpaid caring responsibilities, are at risk of *precarization*. Healthcare institutions should therefore include anti-racism as a strategy to foster 'sustainable employability' of care workers. Governmental policy makers have to reflect upon conflicting policy aims, that bear the danger of squeezing women between having to be available as a paid caregiver (in long-term-care institutions) and having to attend to growing moral appeals on unpaid care (for older people). Our findings urge policy makers to develop policy responses that especially serve the younger, lower educated and racialized care workers in our LTC institutions by

creating jobs that allow for financial independence, to particularly support single mothers to sustain their families while working in LTC.

AUTHOR CONTRIBUTIONS

SD, TA, OP, YAJ, NS, CM, ZB, PV: Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. SD, TA, PV: Involved in drafting the manuscript or revising it critically for important intellectual content. SD, TA, OP, YAJ, NS, CM, ZB, PV: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. SD, TA, OP, YAJ, NS, CM, ZB, PV: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE): Substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content.

ACKNOWLEDGEMENTS

We would like to thank dr. Christine Dedding and dr. Maaïke Muntinga for their critical appraisal of earlier versions of this manuscript. We would like to thank all members of the steering group of 'Negotiating Health' for their feedback on preliminary findings and their help and support in conducting this study.

FUNDING INFORMATION

This study was funded by the Netherlands Organization for Health Research and Development (grant number 849200012).

CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

PEER REVIEW

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.15470>.

DATA AVAILABILITY STATEMENT

The (anonymous) data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Saskia Elise Duijs  <https://orcid.org/0000-0002-5678-5340>

Tineke Abma  <https://orcid.org/0000-0002-8902-322X>

Petra Verdonk  <https://orcid.org/0000-0003-0464-8210>

REFERENCES

Abma, T., Banks, S., Cook, T., Dias, S., Madsen, W., Springett, J., & Wright, M. T. (2019). *Participatory research for health and social well-being*. Springer International Publishing.

- Ahl, H., & Marlow, S. (2021). Exploring the false promise of entrepreneurship through a postfeminist critique of the enterprise policy discourse in Sweden and the UK. *Human Relations*, 74(1), 41–68. <https://doi.org/10.1177/0018726719848480>
- Anderson, N., & Hughes, K. D. (2010). The business of caring: Women's self-employment and the marketization of care. *Gender, Work and Organization*, 17(4), 381–405.
- Bari, L., Turner, T., & O'Sullivan, M. (2021). Gender differences in solo self-employment: Gendered flexibility and the effects of parenthood. *Gender, Work and Organization*, 28(6), 2180–2198.
- Berg, V. d. (2021). *Werk is geen oplossing*. Amsterdam University Press.
- Bhattacharya, T. (2016). *Social reproduction theory: Remapping class re-centering oppression*. Polity Press.
- Bodin, T., Çağlayan, Ç., Garde, A. H., Gnesi, M., Jonsson, J., Kiran, S., Kreshpaj, B., Leinonen, T., Mehlum, I. S., Nena, E., Orellana, C., Peckham, T., Seixas, N., Vanroelen, C., & Julià, M. (2020). Precarious employment in occupational health—An OMEGA-NET working group position paper. *Scandinavian Journal of Work, Environment & Health*, 46(3), 321–329.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Burke, A. (2015). Introduction: A freelancing and self-employment research agenda. In A. E. Burke (Ed.), *The handbook of research on freelancing and self-employment*. Senate Hall Academic Publishing.
- Central Bureau for Statistics. (2019). *Van werkenden loopt zzp'ers meest risico op armoede*. [Among the working population, self-employed are most at risk for poverty]. Central Bureau for Statistics. <https://www.cbs.nl/nl-nl/nieuws/2019/10/van-werkenden-loopt-zzp-er-meest-e-risico-op-armoede>
- Central Bureau for Statistics (2020) *Meer zelfstandigen in zakelijke dienstverlening en zorg*. [More self-employed workers in business services and health and social care]. Central Bureau for Statistics. Retrieved 28 January 2022, from <https://www.cbs.nl/nl-nl/nieuws/2020/05/meer-zelfstandigen-in-zakelijke-dienstverlening-en-zorg>
- Central Bureau for Statistics. (n.d.). *Is elders in de eu het aandeel zzp-ers zo hoog als in Nederland*. [Is there any other country with such a high number of self-employed workers as in the Netherlands]. Central Bureau for Statistics. Retrieved 28 January 2022, from <https://www.cbs.nl/nl-nl/dossier/dossier-zzp/hoofdcategorieen/is-elders-in-de-eu-het-aandeel-zzp-ers-zo-hoog-als-in-nederland>
- Commissie Regulering van Werk. (2020). *In wat voor land willen wij werken? Rapport* [What kind of country do we want to work in? Policy report]. Ministry of Social Affairs and Employment. <https://www.rijksoverheid.nl/documenten/rapporten/2020/01/23/rapport-in-wat-voor-land-willen-wij-werken>
- Conen, W., & Schippers, J. (Eds.). (2019). *Self-employment as precarious work: A European perspective*. Edward Elgar.
- Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law*, 43, 1241.
- de Boer, A. (2017). *Wie maakt het verschil. Sociale ongelijkheid in condities en consequenties van informele hulp*. Sociaal en Cultureel Planbureau.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research*. Sage.
- Duijs, S. E., Abma, T., Schrijver, J., Bourik, Z., Abena-Jaspers, Y., Jhingoeri, U., Plak, O., Senoussi, N., & Verdonk, P. (2022). Navigating voice, vocabulary and silence: Developing critical consciousness in a photovoice project with (un) paid care workers in long-term care. *International Journal of Environmental Research and Public Health*, 19(9), 5570.
- Duijs, S. E., Haremaker, A., Bourik, Z., Abma, T. A., & Verdonk, P. (2021). Pushed to the margins and stretched to the limit: Experiences of freelance eldercare workers during the Covid-19 pandemic in The Netherlands. *Feminist Economics*, 27(1–2), 217–235.
- Duijs, S.E., Wees, M., Abma, T.A., Bourik, Z., Jhingoeri, U., Plak, O., Abena-Jaspers, Y., Senoussi, N., Verdonk, P. (submitted) "We just

- take care of each other" Relational health strategies of nurses and nursing aides working in residential long-term care as a mechanism of in and exclusion in care teams.
- Frambach, J. M., van der Vleuten, C. P., & Durning, S. J. (2013). AM last page: Quality criteria in qualitative and quantitative research. *Academic Medicine*, 88(4), 552.
- Fricke, M. (2007). *Epistemic injustice: The power and ethics of knowing*. Oxford University Press.
- Gadamer, H. G. (1960). *Truth and method*. A&C Black.
- Green, J., & Thorogood, N. (2018). *Qualitative methods for health research* (4th ed.). Sage.
- Hancock, A. M. (2007). Intersectionality as a normative and empirical paradigm. *Politics & Gender*, 3(2), 248–254.
- Hankivsky, O. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science & Medicine*, 74(11), 1712–1720.
- Hochstenbach, C. (2022). *Uitgewoond. Waarom het hoog tijd is voor een nieuwe woonpolitiek*. Das Mag.
- House of Representatives. (2020). Ongekend Onrecht. Verslag parlementaire ondervragingscommissie kinderopvangtoeslag. https://www.tweedekamer.nl/sites/default/files/atoms/files/20201217_eindverslag_parlementaire_ondervragingscommissie_kinderopvangtoeslag.pdf
- Hunting, G. (2014). *Intersectionality-informed qualitative research: A primer*. The Institute for Intersectionality Research & Policy / Simon Fraser University.
- Jakobsen, L., Wachter Qvistgaard, L., Trettin, B., & Juel Rothmann, M. (2021). Entrepreneurship and nurse entrepreneurs lead the way to the development of nurses' role and professional identity in clinical practice: A qualitative study. *Journal of Advanced Nursing*, 77(10), 4142–4155.
- Julià, M., Vanroelen, C., Bosmans, K., Van Aerden, K., & Benach, J. (2017). Precarious employment and quality of employment in relation to health and well-being in Europe. *International Journal of Health Services*, 47(3), 389–409.
- Kalleberg, A. L., & Vallas, S. P. (Eds.). (2017). *Precarious work*. Emerald Group Publishing.
- Karatas-Ozkan, M. (2018). Diversity dimensions of entrepreneurship. In J.-F. Chanlat & M. Ozbilgin (Eds.), *Diversity and management*. Emerald Publishing.
- Knight, M. (2016). Race-ing, classing and gendering racialized Women's participation in entrepreneurship. *Gender, Work and Organization*, 23, 310–327. <https://doi.org/10.1111/gwao.12060>
- Kreshpaj, B., Orellana, C., Burström, B., Davis, L., Hemmingsson, T., Johansson, G., Kjellberg, K., Jonsson, J., Wegman, D. H., & Bodin, T. (2020). What is precarious employment? A systematic review of definitions and operationalizations from quantitative and qualitative studies. *Scandinavian Journal of Work, Environment & Health*, 46(3), 235–247.
- Lorey, I. (2015). *State of insecurity: Government of the precarious*. Verso Books.
- Maarse, J. H., & Jeurissen, P. P. (2016). The policy and politics of the 2015 long-term care reform in The Netherlands. *Health Policy*, 120(3), 241–245.
- McAdam, M. (2013). *Female entrepreneurship*. Routledge.
- McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, 30(3), 1771–1800.
- Mertens, D. M. (2008). *Transformative research and evaluation*. Guilford Press.
- Ministry of Health Welfare and Sports (2020) *Kamerbrief flexibiliseren arbeidsmarkt in de zorg*. [letter to the parliament about the flexibilization of the labour in the health and social care]. Ministry of Health, Welfare and Sports. Retrieved 30 March 2021, from <https://www.rijksoverheid.nl/ministeries/ministerie-van-volksgesondheid-welzijn-en-sport/documenten/kamerstukken/2020/02/10/kamerbrief-over-flexibiliseren-arbeidsmarkt-in-de-zorg>
- Nadin, S. (2007). Entrepreneurial identity in the care sector: Navigating the contradictions. *Women in management Review*, 22(6), 456–467. <https://doi.org/10.1108/09649420710778691>
- Neergård, G.-B. (2020). Entrepreneurial nurses in the literature: A systematic literature review. *Journal of Nursing Management*, 1–11, 905–915. <https://doi.org/10.1111/jonm.13210>
- Ozasir Kacar, S., & Essers, C. (2019). The interplay between identity construction and opportunity structures: Narratives of Turkish migrant women entrepreneurs in the Netherlands. *International Small Business Journal*, 37(7), 713–731.
- Porta, D., Hänninen, S., Siisiäinen, M., & Silvasti, T. (2015). *The new social division: Making and unmaking precariousness* (pp. 1–24). Palgrave Macmillan.
- Purdie-Vaughns, V., & Eibach, R. P. (2008). Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate-group identities. *Sex Roles*, 59(5–6), 377–391.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340.
- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, 33(1), 77–84.
- Schenk, N. (2013). Multiple links: Public policy, family exchanges, well-being and policy endorsement (Dissertation). Erasmus University Rotterdam.
- SER. (2021). *Aan de slag voor de zorg. Een actieagenda voor de zorgarbeidsmarkt*. Sociaal Economische Raad.
- Stanford, J. (2017). The resurgence of gig work: Historical and theoretical perspectives. *The Economic and Labour Relations Review*, 28(3), 382–401.
- Stuij, M., Muntinga, M., Bakker, M., Bendien, E., & Verdonk, P. (2020). *Secundaire intersectionele analyse in kwalitatief gezondheidszorgonderzoek (toolkit)*. Amsterdam UMC, afdeling Ethiek, Recht en Humaniora.
- Syed, I. U. (2020). Racism, racialization, and health equity in Canadian residential long-term care: A case study in Toronto. *Social Science & Medicine*, 265, 113524.
- Tao, Y., Essers, C., & Pijpers, R. (2021). Family and identity: Intersectionality in the lived experiences of second-generation entrepreneurs of Chinese origin in The Netherlands. *Journal of Small Business Management*, 59(6), 1152–1179.
- The Combahee River Collective. (1977) The Combahee River Collective Statement.
- The Netherlands Chamber of Commerce. (2022). ZZZP'er in de Zorg. <https://www.kvk.nl/advies-en-informatie/bedrijf-starten/start-situaties/zzp'er-in-de-zorg/>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357.
- Tuinman, A. (2021). Nursing in long-term institutional care: An examination of the process of care. Doctoral dissertation, University of Groningen.
- van Wieringen, M., Kee, K., Gobbens, R. J., Nies, H., Beersma, B., & Groenewegen, P. (2022). Exploring crucial programme characteristics and group mechanisms of an empowerment programme for certified nursing assistants—A qualitative study. *Journal of Advanced Nursing*.
- Verdonk, P., Muntinga, M., Leyerzapf, H., & Abma, T. (2019). From gender sensitivity to an intersectionality and participatory approach in health research and public policy in The Netherlands. In *The Palgrave handbook of intersectionality in public policy* (pp. 413–432). Palgrave Macmillan.
- Vosko, L. F., & Zukewich, N. (2006). Precarious by choice? Gender and self-employment. In *Precarious employment: Understanding labour market insecurity in Canada* (pp. 67–89). McGill-Queens University Press.

- Wallerstein, N., & Duran, B. (2017). The theoretical, historical and practice roots of CBPR community-based participatory research for health. *Advancing Social and Health Equity*, 17–29.
- Wall, S. (2015). Dimensions of precariousness in an emerging sector of self-employment: A study of self-employed nurses. *Gender, Work and Organization*, 22(3), 221–236.
- Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, 24(3), 369–387.
- van Wees, M., Duijs, S.E., Mazurel, C., Abma, T., Verdonk, P. (in press) Negotiating Masculinity at the Expense of Health: A qualitative study on men working in long-term care in the Netherlands from an intersectional perspective. *Gender, Work & Organization*.
- Wright, M. T., Springett, J., & Kongats, K. (2018). What is participatory health research? In *Participatory Health Research* (pp. 3–15). Springer.
- WRR (2021). Houdbare Zorg. Ervaringen en lessen uit andere landen. Working paper. Den Haag: Wetenschappelijke Raad voor het Regeringsbeleid.

How to cite this article: Duijs, S. E., Abma, T., Plak, O., Jhingoeri, U., Abena-Jaspers, Y., Senoussi, N., Mazurel, C., Bourik, Z., & Verdonk, P. (2023). Squeezed out: Experienced precariousness of self-employed care workers in residential long-term care, from an intersectional perspective. *Journal of Advanced Nursing*, 79, 1799–1814. <https://doi.org/10.1111/jan.15470>

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- High-impact forum: the world's most cited nursing journal, with an Impact Factor of 2.561 – ranked 6/123 in the 2019 ISI Journal Citation Reports © (Nursing; Social Science).
- Most read nursing journal in the world: over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 6,000 in developing countries with free or low cost access).
- Fast and easy online submission: online submission at <http://mc.manuscriptcentral.com/jan>.
- Positive publishing experience: rapid double-blind peer review with constructive feedback.
- Rapid online publication in five weeks: average time from final manuscript arriving in production to online publication.
- Online Open: the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).