

Working with Less, Giving More:

The Impact of Undervaluation on Healthcare Personnel in
Dutch Elderly Homes.

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Abstract

The undervaluation of healthcare work in the Netherlands, which is driven by social biases, gendered perceptions, and underfunding, has a big influence on the healthcare workers within elderly homes. This undervaluation not only affects the well-being and motivation of working in elderly homes, but it also threatens the stability of the healthcare system and the well-being of those who depend on it. This thesis examines the way structural social and financial undervaluation of the Dutch elderly care system has impacted healthcare professionals working in it, on their daily work practices, their mental and physical well-being, the way they deal with this, and the changes that are needed. This research uses a mixed methods approach, in which semi-structured interviews, informal conversations, and a questionnaire are used to explore the impact of the devaluation of elderly care on healthcare personnel in the Netherlands. The gathered qualitative data provided in-depth insights into the experiences and challenges of nurses, carers, managers, and labor union representatives. In contrast, quantitative data from 167 valid survey responses allowed for broader analysis and generalization. This approach enabled a comprehensive understanding of how undervaluation affects well-being, professional satisfaction, and systemic functioning in elderly care. The results and analysis of the data lead to the conclusion that the undervaluation of elderly care in the Netherlands has led to staff shortages, high workloads, and a disturbed work-private balance, limiting meaningful time with residents and causing stress, burnout, and physical strain among caregivers. Despite these challenges, many remain dedicated due to a deep sense of purpose and connection with residents. However, a gap between policy and the work floor leaves healthcare personnel feeling like they are merely ‘surviving’. While innovations may ease pressure, they must match staff needs. This study highlights the resilience of care workers despite the undervaluation and the urgent need for structural and societal change.

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Introduction

Healthcare workers, the backbone of our medical system, are often underrecognized, undervalued, and underpaid, a problem that has persisted for far too long (Limani, 2023). Nurses, caregivers, and other healthcare personnel often do not get the recognition, appreciation, or fair compensation they deserve for doing their vital and essential work. The lack of value leads to problems within healthcare facilities and for the workers themselves, which influences the way care can be provided to patients. The undervaluation not only affects them but also weakens the entire healthcare system.

On a social level, healthcare work is often devalued, as the work is often seen as something that is 'less skilled' or as work that comes naturally, especially when done by women (Teresa-Morales et al., 2022). The expertise and training that is required are not recognized, nor is the vital role nurses and caregivers play in patient care. The effort and feeling these people put into their work are often overlooked and taken for granted until a crisis occurs, which highlights their importance again. The lack of consistent recognition of healthcare work(ers) makes society value their contributions less. Additionally, certain relationships within healthcare institutions do not contribute to feeling valued by nurses and caregivers.

The financial undervaluation of healthcare work follows directly from the societal biases and values, as it comes back in governmental policies and regulations. For years, cutbacks have been made on the health sector by the Dutch government (Bohn Stafleu van Loghum, 2012a), of which the effects are noticeable across all different health institutions. Currently, with unchanged policies, there will be about €700 million less available for long-term elderly care in 2025. This threatens to hinder the necessary transition in elderly care (BDO, 2024). Risking weakening the healthcare sector for elderly care, especially at a time when shortages are already critical, and the quality and accessibility of care is under pressure. The financial constraints and working conditions have discouraged many from entering the nursing profession, contributing to a shortage of trained professionals. By the end of 2021, more than 50 thousand vacancies remained open in the Dutch healthcare sector, which is more than a 60% increase from three years earlier (Wessels & Lensen, 2023). Some personnel who remained are leaving the profession due to personal circumstances and poor conditions, while a growing number choose for self-employment (10% of all healthcare personnel) (Wessels & Lensen, 2023), creating a difficult system that struggles to meet the needs of the care-receivers. All these factors have a big influence on how nurses and other caregivers experience their work personally and the ability of the way they can deliver the care.

In healthcare in general and elderly care in particular, there are large staff shortages, absenteeism, and healthcare providers experience many disturbances of administrative burdens of their work, among others (Rijksoverheid, 2023). Next to that, does the increasing complexity of elderly care set a good example of how the current healthcare system, and the valuation of it, is not fitting anymore. There is a big ageing population in the Netherlands, who increasingly have more complex care needs (Bowman, 2007), while at the same time, there are limited available places in care homes (De Gier, 2010). The Netherlands will count, according to the CBS (n.d.), in 2040 an expected amount of 1.6 million people over 80 years old, that is almost 800 thousand more than in 2020. Meanwhile, care personnel will still decline and face other difficulties in the elderly homes. This all forces the care institutions to arrange their care differently. Elderly people have to stay longer in their own homes, and healthcare personnel must be distributed in a different way. There is a high chance this situation will only worsen unless the root causes of the care deficit are addressed.

If work of healthcare professionals keeps being undervalued, there is a risk the healthcare system further degrades, which has high consequences for the people working in it and the people who are in need of

care. By showing the different ways, healthcare professionals are affected by societal and financial undervaluation this thesis will show that it is time for change, before the system collapses under the weight of its own neglect.

From the literature, it becomes apparent how undervaluation of healthcare workers stems from social and financial reasons. On a social level, the undervaluation of nursing is rooted in gender biases and societal stereotypes, which frame it as women's work and a low-skilled job. Which leads to a lack of recognition, poor working conditions, and being considered as holding a low status in society (Aca et al., 2025; Glerean et al., 2017; Teresa-Morales et al., 2022). Financially, neoliberal policies, and societal undervaluation have led to continuing underinvestment in healthcare and nursing, treating it as something low-skilled rather than essential work. This, combined with privatization and reduced public funding, has increased care deficits and negatively impacts the working conditions of nurses (Andersson & Kvist, 2015; Garnham, 2017; Tronto, 2013). Research by Burns et al. (2016) and Dowling (2022) highlights how cutbacks have led to staff shortages, increased workloads, and deteriorating job quality, contributing to stress and alienation among care workers. Studies by Aiken et al. (2013), Rajbhandary & Basu (2010), and Bogyo (2024) further emphasize the links between poor working conditions, burnout, absenteeism, and declining quality of care. However, the ways in which the structural undervaluation of care has personally impacted healthcare personnel, in terms of their mental and physical health, as well as their professional satisfaction, and how these effects are present within the specific context of Dutch nursing homes, remains little studied in the existing academic literature.

To address this research gap, this thesis focuses on the personal experiences of healthcare professionals working within Dutch nursing homes. It seeks to explore how undervaluation is perceived by those on the floor, and how it influences their daily work, well-being, and professional satisfaction. By showing the personal experiences and perspectives of care workers, this study aims to provide a deeper understanding of the challenges they face within the Dutch nursing homes, and to suggest ways to improve their working conditions.

For this thesis a mixed-methods approach is used, combining both quantitative and qualitative data. For the qualitative data, 11 people from various positions within the care homes and the healthcare industry were interviewed, and informal conversations were held. Themes that were discussed in the interview regarded daily work practices, their mental and physical health, and ways these healthcare professionals deal with certain effects of the undervaluation. This data was then transcribed and later analyzed by the use of deductive coding. The quantitative data was gathered by sending out a questionnaire to a large database consisting of members of the labor union NU'91, who are all healthcare professionals, leading to 167 usable responses of the questionnaire. The questions in the questionnaire contained similar themes as that of the interview. The data is analyzed by frequencies, means, and regression analyses, which are used to statistically back up statements made in the interviews and make broader generalizations. An internship at NU'91, a labor union for healthcare professionals, was done during the research period. This position provided unique access to relevant participants within this system and offered valuable insights into the structural challenges faced by healthcare workers and the union's advocacy efforts.

The research objective of this thesis is to analyze how the undervaluation of care and the by coming cutbacks and other consequences really affected the nurses and other healthcare personnel in Dutch elderly homes. How are they devalued, what things changed in their daily work practices, how it affects them on a personal level, how satisfied they are with the work they do and deliver, what are the ways in which they navigate and respond to these conditions, and what needs to change within the system. The central research question of this thesis is: *In what way has the undervaluation of healthcare in the*

Netherlands impacted the daily work practices, and well-being of healthcare personnel in Dutch elderly homes? The central research question is divided into sub-questions in order to be able to answer all the different aspects of the question.

1. How is the functioning of different systems within Dutch elderly homes impacted (e.g., staffing, resource allocation)?
2. What are the consequences for the well-being and professional satisfaction of healthcare personnel working in Dutch elderly homes?
3. How does the elderly care respond to the challenging conditions, and what should change?

Literature Review

This chapter describes the academic literature that was used to form a theoretical framework around the topic of undervaluation of elderly care. It conceptualizes different aspects of nursing and caring, starting with the question of what care and caring is, and what care within a nursing home involves. The chapter provides an overview of the value of care, both socially and financially, and examines what already is written on the effects of the undervaluation on nurses. Furthermore, it explores how undervaluation impacts working conditions, and what different aspects are affected by this. The literature review concludes with the conceptual framework, by which this thesis is structured.

Caring

Care can be defined in several ways; one universal definition does not exist, as it depends on the context it is placed in. Care is multifaceted, interconnected and is acted out differently at various points along the health trajectory (Kalfoss & Cand, 2015). Hermanns and Mastel-Smith (2012) put care as something involving assisting someone who cannot fully care for their own physical, mental, emotional, and/or social needs. Effective caregiving relies on specific personal characteristics like emotions, abilities, knowledge, time, and a meaningful emotional bond with the person receiving care. Traditionally, care is a social activity that has been provided mostly by women, it was part of the tasks within households (Dowling, 2022). In the past, aside from urgent care in hospitals, people who had any form of a long-term illness (mental or physical) were taken care of within families at home. This work was done nonstop by women and a few others as part of a never-changing routine. However, with the start of modern economic growth, things began to change (Dowling 2022). Care has become more seen as something to be outsourced to third parties. While care can and still is done by friends and family members, it is now mainly done by professionals in various health institutions. The professionals who ‘care’ are mostly nurses and caregivers, who work in all kinds of health institutions, like hospitals, clinics, or nursing homes.

Caring as a nurse consists of various levels that explain why it is done, how it is done, and what the consequences are (Swanson, 1999). The first level, ‘capacity of caring’, describes the characteristics that enable someone to deliver good care. Key traits include compassion, empathy, knowledge, confidence, and reflection (Swanson, 1999), which can develop with experience within the profession (Benner, 1984). The second level, ‘concerns and commitments’, refers to how people engage with the world and what they value (Swanson, 1999). It involves a personal connection where people and things matter, which motivates caring actions. Caring could be a call to duty, an act of love, or could be both. Caring is based on commitments to recognize each person’s dignity and value, addressing their needs, building a connection, acting ethically, and staying true to oneself as a nurse. This commitment can also come from cultural backgrounds, where in some cultures caring for someone is much more natural, and in other cultures people are more reliant on self-care in that sense (Swanson, 1999). The third level of caring as a nurse is ‘caring conditions’, which refers to the factors that influence caring interactions, these can enhance or limit care. Conditions that influence the caring of a nurse are categorized into *patient-related conditions* (e.g., communication, health problems), *nurse-related conditions* (e.g., resources, personal/professional constraints), and *organization-related conditions* (e.g., technology, administration, work conditions) (Swanson, 1999). The fourth level, ‘caring actions,’ explains the elements that are part of caring behavior for nurses. This includes, among others, listening to the patient, allowing expression of feeling, getting to know a patient, putting the patient first, giving treatments and medications. When expressing these caring actions, they feel confident that adequate care was provided (Swanson, 1999). The way nursing behavior is executed highly differs per nurse and could explain why some nurses are perceived as ‘better’ than others by patients. The fifth and final level, ‘caring

consequences,' refers to how caring is centered in being genuine and selflessly supporting others, which creates positive and uplifting outcomes (Beck, 1994). Caring strengthens both caregiver and care-receiver, influencing growth and well-being. Its effects can be on an *emotional/spiritual level* (e.g., self-esteem, satisfaction), a *physical level* (e.g., healing, comfort), and a *social level* (e.g., trust, meaningful relationships). For more examples, see Table 1.

Table 1. Levels of caring framework.

Level	Category	Details
Level 1	Capacity of caring	Compassionate, Emphatic, knowledgeable, confident, reflective.
Level 2	Concerns / commitments	Recognize each person's dignity and value, addressing their needs, building a connection, acting ethically, staying true to oneself as a nurse, cultural background.
Level 3	Caring conditions	Patient-related conditions: e.g., communication, personality, health problems, care needs. Nurse-related conditions: e.g., resources, constraints, and demands on personal and professional level. Organization-related conditions: e.g., role related, technology, administration, funding, and work conditions.
Level 4	Caring actions	Listening to the patient, allowing expression of feelings, getting to know a patient, putting the patient first, giving treatments and medications, etc.
Level 5	Caring consequences	Emotional/spiritual level: e.g., enhanced self-esteem, positive mental attitude, satisfaction with care. Physical level: e.g., enhanced healing, feeling safe, increased physical comfort. Social level: e.g., meaningful reciprocal relationship, family empowered, trust in someone to count on.

Note. Adapted from Swanson (1999).

Nursing Homes

Nursing homes have an important role in providing care to older dependent people, and with the current aging population, the need for nursing healthcare will keep increasing (Spilsbury et al., 2011). According to Spilsbury et al. (2011), there are three primary groups of residents in nursing homes, each group demands a different type of care, management, and treatment. **(1)** There are those who are recovering from acute illnesses who require rehabilitation. Older adults are more likely to experience multiple deceases and disabilities at once, and they generally require more time to recover from acute illnesses (Wang et al., 2019). Within the acute illness and rehabilitation care the patients are not allowed to stay an extended amount of time in a rehabilitation center, their hospitalization is limited. Compared to the general adult population, older adults have a lower physiological reserve and take longer to recover from illnesses (Wang et al., 2019). This means that the care is also extended outside of the rehabilitation center for older people, to try and cure them as good as possible. **(2)** There are also residents who are in the terminal stages of their illness. These people receive palliative care, which is a comprehensive, interdisciplinary approach designed to ease suffering for people with advanced and terminal illnesses, as well as support their families (Meier et al., 2010). These people are not tried to be made better, but their pain is eased. **(3)** The final primary group in nursing homes consists of those with chronic conditions, combined with cognitive or functional impairments. As people are getting older nowadays, there is a visible increase in residents with progressive chronic conditions, who require more intensive care and resources than used to be required in nursing homes (Bowman, 2007). These residents can have a combination of mental and physical deceases but still have a quality of life. In the nursing homes, they are helped with their Activities of Daily Living (ADL), e.g., eating, bathing, and also with their medical health, receiving treatments, and things like physiotherapy.

Care workers for the elderly range from physicians, nurses, psychologists, community health workers, to doctors, who provide care in nursing homes (Cohen et al., 2006). In terms of nurses in the Netherlands, there are different 'levels' of nursing, depending on the type of education completed. There are the MBO-trained nurse, the HBO-trained nurse, and nursing assistants (verzorgende IG). According to a professional profile ('beroepsprofiel') about future-proof professions in nursing and care, in a collaboration between several healthcare organizations in the Netherlands, the following description is given for the different nursing functions (V&VN et al., n.d.):

- A nursing assistant provides personal care, guidance with Activities of Daily Living (ADL), supports self-management, and works together with other healthcare professionals to maintain or improve the functioning and quality of life of care recipients.
- An MBO nurse provides nursing care and psychosocial guidance, makes nursing diagnoses, coordinates care, draws up and evaluates care plans, and carries out reserved actions, whereby the care situations are often plannable and of limited complexity.
- An HBO nurse is responsible for coordinating care processes, performing complex nursing procedures based on clinical reasoning, and promoting self-management among care recipients, while also contributing to quality care and innovation within healthcare.

Care in elderly homes is thus a combination of both health care and social care, in which different types of tasks are combined. According to Boorsma et al. (2012), more than 70% of nursing home residents require professional care, such as assistance with activities of daily living, nursing (medication, wound care), and other assistance. The residents suffer from various chronic diseases and accompanying disabilities. Nurses have to balance these two types of care within their workdays. The health care aspect involves handing out medications, monitoring vital signs, and responding to medical emergencies (V&VN et al., n.d.). At the same time, nurses also have to provide social care by assisting residents with daily activities like eating, bathing, getting dressed, as well as offering comfort and company to the residents (V&VN et al., n.d.). Both of these responsibilities can be challenging as nurses have to switch between technical/medical activities to more personal, sometimes emotionally heavy aspects of the social side of the care they provide. The struggle becomes even more visible with issues like understaffing and high workloads, which have a big impact on the nurses themselves (Aiken et al., 2013). As the healthcare aspect tasks are things that have to be completed for the health of the residents, social care often receives less attention and recognition. Despite it being equally important for the well-being of the residents (Drageset, 2004).

Staffing in nursing homes is a significant concern, due to the difficulty in finding enough staff members, and the right educated staff who are capable of addressing the diverse and complex needs of residents. Spilsbury et al. (2011) state several variables that determine the quality of care provided in nursing homes. First of all, a logical one is the number of staffing, which is very important, this determines whether there are enough nurses to provide the care and fill in all the shifts. Then, worker stability, which tells something about the consistency and continuity of staff members in a nursing home setting. It includes factors like how long staff members stay in their positions, their level of commitment to the organization, and the extent to which there is turnover or frequent staff changes. Another variable is the staffing levels, which says something about what the nurses working in a facility are licensed for, what procedures they can or cannot execute. And in which way they were trained and have gained experience. Furthermore, the use of agencies to fill in the gaps in the schedule has an influence as well, residents' satisfaction with care is strongly affected by the quality of their interactions with staff. Residents indicate how familiarity and bonds with caregivers are very important in shaping their views on the quality of care (Spilsbury et al., 2011). Finally, the ways in which care is organized and managed in the home may

determine the effectiveness of staff performance and their relationship to quality of care for residents (Spilsbury et al., 2011).

Residents of nursing homes are elderly people with fragile health and complex needs who are dependent on specialized nursing care. Understanding their perspectives regarding their interpersonal interactions is essential to deliver high-quality care (Nakrem et al., 2011). Such care requires a balanced approach that addresses medical, physical, psychosocial, and interpersonal aspects (Nakrem et al., 2011). Since residents are often highly dependent on the nursing staff, it is crucial to keep their dignity high, by treating each resident as an individual with their own unique needs. Building relationships through regular interactions helps nurses understand and meet these needs more effectively. Wilson et al. (2009) describe how most relationships between nurses and residents are built through informal and frequent interactions during caring activities, not only between staff and residents, but also with the inclusion of family members. A key element in this is the sharing of personal stories, which helps with making sense of how the residents experience certain interactions, and it is central to involving them in decision-making (Barnes, 2005). Collaboration between relatives and healthcare professionals is crucial within elderly care (Waardigheid en Trots, 2024). Involving them in the process helps identify better ways in which care can be provided to their family member. For example, if family members and residents share stories about their background during orientation, it helps to create a better understanding of certain behaviors of residents and how they can provide higher-quality care to them (Wilson et al., 2009). Daily care processes shape the experiences and the perceived quality of care in the nursing homes.

The Value of Care

Nursing homes serve as crucial organizations for the care of the elderly, requiring a combination of medical, emotional, and daily living support. However, the working conditions within these facilities and how it is experienced by the nurses and carers reflect broader societal issues of how care work is valued and often undervalued. The value people put on something is very subjective, depending on experiences, knowledge, and what they find important. The value of a product or service is not something that they have naturally on their own, value is something that people assign to them based on certain factors, like how meaningful, useful, or desirable they are in a certain situation (Perry, 1914). Perry (1914) describes value as something that emerges through relationships, judgements, and contextual factors, rather than something that is an entity on its own. Thus, the value of a product or service is different for everyone, it depends on the relationship you have with it, the ideas or prejudices you have about it, or the way in which you are interacting with it. Values can be based on stereotypes, on things that are ‘common knowledge’ about certain things, people, or jobs. People assume, due to the stereotypes, that the value others give to it has to be true, especially if they do not have knowledge about it themselves.

Culture and values are at the heart of public policy (Muers, 2018). The value society places on certain jobs or services is reflected in governmental policies and regulations. These are shaped by collective judgments of value, which are based on historical, cultural, and social contexts. However, the values expressed in policy are not always fair or accurate, which can result in unequal recognition or compensation of certain professions or roles. It is often seen that healthcare work gets undervalued financially and within society. It is seen as something that is not that important or that comes naturally to people, rather than as skilled labor that deserves appropriate economic compensation.

Social value of care

Nursing and caring is socially undervalued, the value society gives to something is based on stereotypes and biases, leading to it not getting the recognition it deserves. A study by Teresa-Morales et al. (2022)

highlights how value is based on two stereotypes, one relating to the gender identity of nursing professionals, and the second relating to the characteristics of the profession.

The undervaluation of nursing is deeply rooted in gender biases, as nursing is commonly seen as 'women's work', leading to opinions that it is less demanding or important, as it comes 'naturally' to women (Teresa-Morales et al., 2022). Nursing is considered to be a feminine job, suitable for women (Glerean et al., 2017). This is caused by the fact that women are traditionally more associated with caregiving, which is seen as part of their nature. These traits are also associated with nurses, reinforcing the perception that they are better suited for the profession than males are. And when males are working in the nursing field, they often are faced with negative stereotypes and biases, questioning their masculinity and competence, especially in more patriarchal cultures. A study by Aca et al. (2025) confirms that nurses, especially female ones, are often undervalued and seen as lacking specialized expertise, which has a negative effect on their confidence and their professional identity. Gender discrimination reinforces traditional roles that society sees as 'natural' for women, such as caregiving. This normalization makes the inequalities seem acceptable and normal, preventing meaningful change. As a result, these biases get integrated into social structures of society, making it harder to challenge or diminish the issues that keep nurses and caregivers, especially women, in these undervalued positions (Aca et al., 2025).

Additionally, nursing is often dismissed as a low-prestige and low-skilled profession, where limited academic training is required and the people working in it have little autonomy in their job (Teresa-Morales et al., 2022). This perception puts nursing as something inferior in the medical field, contributing to the broader societal devaluation of the often unrecognized essential and specialized work nurses perform. Girvin et al. (2016) add to this that nursing is seen as a low-image profession by many people. A study by Glerean et al. (2017) confirms this by stating how the status of the nursing profession in society is considered to be low. Nursing is, however, seen as something that is meaningful, needed, and respected, but still, it has low prestige and a low status in society. Teresa-Morales et al. (2022) describe how even nurses themselves now hold certain prejudices of their own work and see what they do as something that is of lower value than other healthcare disciplines, reflected by working conditions with low pay and professional esteem.

While the value of nursing has grown some public appreciation, especially due to the response to the COVID-19 pandemic (Rojas-Ocaña et al., 2020), this increased recognition has not resulted in more acknowledgment or recognition of true significance for the nursing profession and its contributions. To address this lack of recognition and undervaluation, it is important to show that nursing is a specialized and scientific profession. There should be better representation in media, more involvement in healthcare policies that raise the status of the profession and recognize the important skills and work of nurses (Teresa-Morales et al., 2022).

Financial value of care

Due to the low recognition of the profession by society and the social undervaluation, the policies for better working conditions and better pay for nurses sort of got lost in the public regulations. As care labor is largely performed by women and often immigrant groups, it has historically been undervalued and underpaid. Shifting processes and priorities in regulation in combination with neoliberal policies have made this worse, by treating care work as something that is low-skill and a low-status occupation, rather than a much-needed and skilled occupation that is important for a functioning society. The cultural and economic devaluation of care has led to persistent underinvestment in the workforce and cutbacks in funding by the governments. Which led to many negative effects on the nurses and to a care deficit. The care deficits are not only a reflection of insufficient government funding, but also a systemic failure

to recognize the important role of care and its workers in our society. The rise of political neoliberalism strengthens this by promoting privatization and reducing public spending, which directly impacts funding for public services (Garnham, 2017), such as care institutions.

Growing political neo-liberalization influences the public funding (Garnham, 2017), for example, for care institutions. Neoliberal policies involve the promotion of free markets, individual responsibility, and global homogeneity (Birch, 2015). In the healthcare neoliberalism promotes these aspects by promoting reduced government intervention and a bigger role for private and market-driven healthcare systems. It would encourage competition among private organizations, assuming that this will lead to the highest efficiency and improved quality of care. This results in healthcare services being more and more privatized, with a focus on cost reduction and profit generation, rather than access or equity. With these neoliberal policies, the responsibility of health is shifted onto individuals, in which they have to pay for services, which can deepen inequalities for those with fewer financial resources. Furthermore, does neoliberalism push for a more standardized global approach to healthcare, where countries adopt similar market-oriented models. This disregards local needs, values, and cultural contexts of different countries or regions. With this system, a form of healthcare is created that prioritizes efficiency and profitability over social responsibility and collective well-being. By this people working in it and people in need of healthcare are affected.

As most of the care organizations are publicly funded, these neoliberal policies with declining funding have a large influence on the organization as a whole, leading to care deficits. The care deficit reflects the incapacity of countries to find enough care workers to meet the needs of the residents. This is caused by the democratic deficit, which refers to the incapacity of governments to reflect the real values and ideas of their citizens. These deficits are connected through the separation of the public and private spheres in a country. Care is seen as a private responsibility and for that gets excluded or limited in public programs of governments (Tronto, 2013). Over the years, there has been a shift in healthcare to delivering more efficient and cost-effective care, where concepts of private markets have been gradually introduced to this public service (Andersson & Kvist, 2015). This stems from neoliberalism and changing priorities, which reduced care to a private matter, favoring market efficiency over human needs. The neoliberal policies worsen care deficits by favoring economic growth and personal interest over the collective responsibilities we share (Tronto, 2013), like caring for the sick, and have a large effect on nurses in the healthcare industry.

Work Conditions of Care Workers

A lot of the problems faced in the work practices and conditions of care workers stem from the value that is given to the care. This value leads to different consequences for the workers, the home, and the people living in it. The influence of this value can for instance be seen in the funding the homes get, and the social recognition they get. In term, this impacts the daily work conditions and well-being of nurses and care workers.

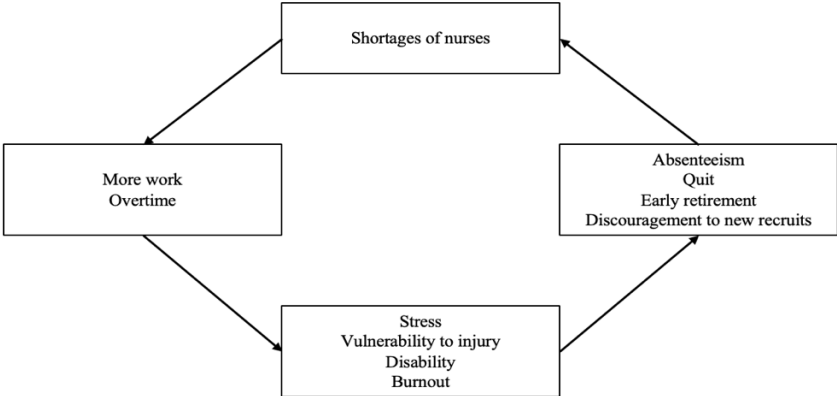
When looking at the financial side of healthcare, the years of cutbacks have a large influence on workers and the conditions in the industry. The study of the impact of cutbacks on care homes in the United Kingdom by Burns et al. (2016) shows how homes and the employees were highly influenced by external financial shock. The homes responded in different ways, for example by cutting labor costs, which leads to worsening of job conditions. Next to that, key aspects that impacted the job quality of workers, was the workers' ability to shield residents from negative effects, which included reduced staffing levels, longer working hours, and increased workload. And while pay cuts were a big concern

for the workers, the indirect consequences of this, fewer staff and longer shifts, had a more direct impact on their ability to provide high-quality care.

A study by Dowling (2022) shows how the work in care facilities has become more unstable, and fewer people are willing to endure these worsened working conditions. Those who do continue to work face increased stress and feelings of alienation to the home and residents. Staff members have less time to spend individual time with their residents, due to the increased work pressures. Before the cutbacks, nurses took the time to really get to know their residents, and when the residents displayed disruptive behavior, the nurses had time to seek the causes rather than the symptoms. By which they found a (better) solution to the disruptive behavior. Now, the workers have less motivation and time to really connect with the residents and spend as much time getting to know them as they would like. Furthermore, Dowling (2022) shows how due to the cutbacks people are less willing to work in poor and hard conditions for the relatively low wages, which enlarges the deficit and puts even more pressure on the remaining workforce (Dowling, 2022). A study by Aiken et al. (2013) highlights that if improvements are not made in the work environment, and working conditions will not improve, nurse shortages will worsen.

Staff shortages are of high concern in nursing homes and have, in most cases, the biggest influence on the working conditions of the employees. Its supply can be seen as a vicious cycle in which every step has a negative influence on the next, worsening the situation (see figure 1). Rajbhandary & Basu (2010) describe how the nursing shortage leads to increased workload and having to work overtime for the remaining staff, this then causes stress, vulnerability to injuries, disability, and burnout. These conditions lead to high absenteeism, people quitting, early retirement, and discouragement of new nurses applying, enlarging the shortage again. As a result, the cycle continues, worsening working conditions and making it harder to attract and keep nurses. This self-reinforcing loop highlights systemic issues in healthcare staffing and the urgent need for structural interventions.

Figure 1. Cycle of shortages in nursing supply.



Note. adapted from Rajbhandary, & Basu (2010).

The working conditions for healthcare professionals are often challenging, and there is a high work pressure leading to significant challenges in the healthcare sector, such as work-related stress and burnout for nurses and carers (Bogyo, 2024). Nurses, in particular, are affected by both internal and external factors, including long hours, the demands of patient care, and the overall work environment and organization of it. These factors affect their well-being, resulting in stressful working conditions and sometimes even resulting in burnout, characterized by emotional exhaustion, depersonalization, and a

reduced sense of accomplishment or job satisfaction. The high levels of stress nurses experience contribute to increased absenteeism (Rajbhandary & Basu, 2010), higher turnover rates, and a decline in the quality of patient care (Jennings, 2008). A study examining nurses' working conditions in 12 European countries highlights several key issues contributing to stress and burnout (Aiken et al., 2013), mostly reported are the high workloads, dissatisfaction with wages, and career opportunities. Many nurses expressed that they want to leave the profession due to inadequate staffing, lack of responsiveness from management, and insufficient resources. Moreover, stressful working conditions are a major factor in illness and injury related absenteeism of nurses (Rajbhandary & Basu, 2010).

Furthermore, differences in nurse education and staffing levels were found to affect the quality of care, with understaffing and lack of time often resulting in uncompleted nursing tasks (Aiken et al., 2013). Nursing homes often suffer from staff shortages, and the level of education of nursing home caregivers is not on pace with the increasing complexity of the care needs of the residents living in it (Boorsma et al., 2012). Thus, nursing education has not adapted or developed with the growing and changing care needs of nursing home residents, making the job much more difficult to do and complete every day.

Another aspect that influences the work of nurses, and how they experience it, is the level of authority and autonomy they have within the organization. Research by Schlinkert and de Groot (2023) shows that this authority plays a crucial role in how nurses experience their work and how resilient they are. When nurses are able to take the space to contribute to the quality of care and safety of care, based on their professional experiences, this will strengthen their sense of influence and involvement. According to this research is experienced resilience is strongly related to factors such as sense of leadership, participation in policy decisions, and a good relationship with managers. Authority over daily work, in particular, appears to be an important factor in how much authority care workers experience. More influence over your own work contributes directly to the well-being and professional strength, and satisfaction of nurses (Schlinkert & de Groot, 2023).

Within organizations, nurses often experience that they are less valued by their superiors or the management. More appreciation and a more equal relationship with superiors would make the work of nurses and carers more attractive. Care staff are very involved in the organization, but this involvement does not always seem to be mutual (Bohn Stafleu van Loghum, 2012b). Research from the Netherlands Institute for Health Care Research (NIVEL) by de Veer et al. (2012) shows that 70% of nurses and carers think the job can be made more attractive by improving the appreciation within the organization and reducing the distance between top management and people on the floor. According to more than 50% of the questioned nurses, the management is not or hardly aware of the actual problems on the work floor. The research further states how a minority (47%) feels sufficiently valued by the management, the distance between management and workers on the floor, therefore, seems to remain large (de Veer et al., 2012).

Workload is a critical factor that influences the conditions and attractiveness of healthcare jobs. Nurses and carers have expressed that making the job more attractive could be achieved by increasing the number of staff at the bedside, reducing administrative tasks, and lowering overall workload. Studies show that if these changes were implemented, many healthcare workers would find the profession more appealing, which could help address staffing shortages (Bohn Stafleu van Loghum, 2012b). Furthermore, improving the work environment, including better staffing levels and more technical support systems, could improve job satisfaction and patient outcomes (Jennings, 2008).

There has been made some progress in acknowledging the importance of involving healthcare workers in their professional development, which has a positive effect on the work experience and thus the

conditions of the nurses. For certain branches of the Dutch healthcare, recently collective labor agreement mandates for UMCs (University Medical Centers) were given out that gives nurses and caregivers a greater say in their professional growth. This includes providing time and resources for training, improving care processes, and engaging in reflection, research, and professional accountability. This is seen as a crucial step in supporting the development of nurses, and the hope is that other healthcare branches will follow this development (Bohn Stafleu van Loghum, 2022).

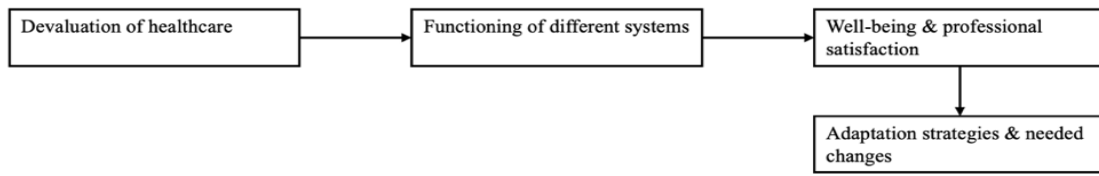
There are high absenteeism rates within the Dutch healthcare sector, these rates show the need for improvements in working conditions to support the health and well-being of healthcare workers. Research by NIVEL (2012) shows that appreciation from leaders remains an area for growth. Next to salary, meaningful recognition includes involvement in decision-making, responsibility, and career development opportunities. Exploring new ways to organize care, such as self-management or different team structures, may help nurses and cares feel more valued and less dependent on external recognition (De Veer et al., 2012). Addressing the internal and external influences that lead to worsened working conditions for nurses is critical for improving both their well-being and the quality of patient care. By focusing on factors like staff support, workload management, and professional development, healthcare organizations can create a healthier and sustainable work environment for nurses and caregivers.

Even though in recent years the importance of healthcare has been shown on different occasions, like COVID-19, and the urgency and need for good care is more present in today's policies. The effects of years of undervaluation are still present. There has been conducted a lot of research on nursing homes and what determines the quality of care in such homes, and how nurses' working conditions are influenced by certain externalities. However, lacking in the literature is the ways in which the structural undervaluation of care has personally impacted healthcare personnel, in terms of their mental and physical health, as well as their professional satisfaction, and what their personal experiences are. This research will contribute to filling that gap by exploring how these effects are present within the specific context of Dutch nursing homes. To address this knowledge gap, this study will examine the effects of healthcare devaluation in the Netherlands on the work practices, professional satisfaction, and well-being of staff in Dutch elderly homes, and how they deal with and respond to this. This research tries to find an answer to the central research question: *In what way has the undervaluation of healthcare in the Netherlands impacted the daily work practices, quality of care, and well-being of healthcare personnel in Dutch elderly homes?*

Conceptual Framework

The conceptual framework of this study can be found in figure 2. In this figure the variables that are analyzed in this study are described, and the relation between them. The devaluation of healthcare can be seen as the cause of the system, the independent variable. The functioning of different systems within the elderly homes is the mediating variable in the system, explaining the relationship from the devaluation to the effects on personal well-being and professional satisfaction. Which is a dependent variable together with the adaptation strategies of the healthcare workers. In each secondary research question, one of the 'steps' of the conceptual framework is researched, by which, in the end, the relationship between all variables can be explained.

Figure 2. Conceptual framework.



Methodology

This chapter explains the methods and procedures used to answer the sub-research questions and the central research question of this thesis. In order to examine the impact of the undervaluation on healthcare personnel in Dutch elderly homes, a mixed-methods study was performed, collecting both qualitative and quantitative data about the case. This research design was chosen as it is most suitable for providing a broader and more complete vision of the problem at hand (Almeida, 2018). In this case, the impact of undervaluation on the functioning of different systems, consequences for the well-being and professional satisfaction, and the response to these impacts within the elderly healthcare sector are examined. The internship at the labor union NU'91 gave opportunities and important and interesting insights to this research.

This research aims to gather data and information about the personal experiences of healthcare personnel, like nurses and carers, on the way they are devalued, and the by coming consequences. The research describes the characteristics of this. Data was gathered by a combination of semi-structured interviews, informal conversations, and a questionnaire. This study design allows for different types of data to be gathered, by which the impact of the devaluation of care can be examined. With the use of the quantitative data, the experiences and stories from the interviews derived from the qualitative data can be generalized and analyzed whether it applies to most of the people in the same position within the healthcare system. Both the qualitative and quantitative data that is used for answering the research questions is primary data collected by the researcher.

Qualitative Data

The qualitative data is gathered by conducting semi-structured interviews and holding informal conversations. According to Kallio et al. (2016), a semi-structured interview method is suitable for studying people's perceptions and opinions on complex or emotionally sensitive issues. In a semi-structured interview, it is possible to focus and shift to topics that are meaningful to the participant, allowing different perceptions to emerge. The structure of the interviews consists of different themes based on concepts coming forward in the researched literature. These themes differed per interviewee, relevant to the function of the person who was interviewed. For nurses and caregivers, questions regarded e.g., daily work practices, their struggles, and their professional satisfaction. Managers were asked about e.g., how policy is arranged, how they support their employees, and how they try to innovate the workplace. Different employees of the labor union were asked about the structure of healthcare in the Netherlands, what they hear from their members, and certain policies that impact elderly care. The interviews took between 20 and 40 minutes. To avoid the situation of losing any information, the interviews were recorded with the permission of the interviewees. After the interviews were conducted, the recordings were turned into transcripts to make the data analysis easier. The transcripts of the interviews have not been added to the appendix for reasons of anonymity and privacy. The interviews are semi-structured, and thus the questions are not constructed beforehand, but a thematic framework is made to lead the interview. Some important themes, with example questions, that were important to be covered were put on an interview guide, additionally, certain statements made in the interviews guided where the interview would go. An overview of the thematic frameworks of the interviews with people of different healthcare functions can be found in [appendix 1](#), for this report the frameworks were translated into English, but in reality, all interviews were conducted in Dutch.

The qualitative data derived from the semi-structured interviews and informal conversations were collected from different actors within the system of this topic. The interviews were conducted with healthcare professionals from two different elderly care organizations. Next to that, several interviews

were conducted at NU'91, a labor union for healthcare professionals, who advocate for the position of nurses and carers. In total 11 people were interviewed, with all kinds of different functions within or for the elderly care sector. Participants for the interviews were recruited through purposive and snowball sampling, making use of existing networks and recommendations from them. This approach allowed for the inclusion of people whose professional backgrounds and experiences were relevant to this research topic. To get a nuanced and broad overview of the experiences of the employees, people with different types of functions were interviewed. In total three nurses/caregivers were interviewed who take care of the elderly every day, two managers were interviewed, who have more knowledge on what goes in within the teams, resource allocation, and policy changes. Several employees from the labor union were interviewed, who negotiate and root for the nurses and other employees, and who hear a lot about what concerns them and what they are up against. Two lawyers were interviewed who have information about personal cases of what healthcare professionals face in their work. Four advocates of the labor union (NU'91) were interviewed, who give a more collective view on what healthcare professionals face in their work.

The qualitative data was gathered by conducting interviews and conversations, in total 11 interviews were held. The transcripts of the interviews gave lots of qualitative data consisting of written text. In order to find the main impact on the quality of care, the consequences of their well-being, and the change in the systems, qualitative data analysis is performed. Deductive coding was used as the method of data analysis of the qualitative data. Predefined themes, which were identified during the literature review and later incorporated into the interview frameworks, were systematically searched for in the interview transcripts. These themes guided the analysis by highlighting the interviewees' perceptions, experiences, and interactions related to them. The different codes that were created from the themes in the interviews and informal conversations are: *Authority and Autonomy (zeggenschap)*; *Coping mechanisms*; *Mental and physical health*; *Policy*; *Professional satisfaction*; *Success stories*; *Value*; *Work pressure*; and *Work-life balance*. In the data analysis, first, the most interesting and useful sentences and data were highlighted in the transcripts. Then, these sentences were linked to the different themes that had previously emerged. With the use of a data coding program (Atlas.ti), all the codes and accompanying data were neatly ordered, allowing them to be clear and convenient to use for the analysis and answering of the research questions. This approach helped explore how these themes influence or come back in the work of healthcare professionals in Dutch elderly care homes.

Informal conversations were held during work and the internship in order to collect more informal and casual qualitative data. This is purely based on conversations going on or what is going on at the workplace. The main messages of these conversations are written down after the conversation, and later it was more elaborated on in the notes. During the internship at labor union NU'91 also multiple meetings were attended, like the discussion of a new collective labor agreement, and a board meeting of a care organization. The information gained from these meetings was also put down as informal conversation data.

Quantitative Data

The quantitative data is gathered by the distribution of a questionnaire amongst nurses and other healthcare professionals. The survey was designed to assess the impacts of the undervaluation of care on the functioning of the system, well-being of healthcare professionals, job satisfaction, quality of care, and how this is navigated and responded to. It includes 23 questions across these four key areas: organization and policy; well-being of healthcare personnel; quality of care and working environment; and navigation and response strategies. The questions used 5-point Likert scales and categorical responses to gather the quantitative data for the analysis. Which is most suitable for these questions

regarding judgmental subjects of the people filling in the questionnaire (Taherdoost, 2022). Every theme was concluded with an open section in which any comments or remarks could be shared, which provided some qualitative data as well. The questionnaire aims to provide a detailed understanding of the consequences and influence of the current system on healthcare personnel. For the full survey format, see [appendix 2](#). The questionnaire is sent out to all members of NU'91, which has a large membership of healthcare professionals to which the survey can be sent. In total 447 responses to the questionnaire were collected.

The collected data from the questionnaire is quantitative data and thus consists of a large data set. In total the survey was filled in 447 times. The data gives an overview of averages and other statistics by which generalizations can be made, for instance, as to how work satisfaction is impacted, if they experienced an impact on their mental health, how they feel valued by their residents, supervisors, or society, and how they deal with challenges in their work. After the data was collected, the answers of the survey were put into an organized spreadsheet. Then the collected data of the survey was 'cleaned' by removing responses of incomplete answers, inconsistent answers, and data of those responses that are irrelevant to the research. The survey was sent to members of NU'91, which includes healthcare professionals from various care branches across the Netherlands. As a result, not all respondents work in the elderly care sector and are therefore not relevant for the topic of this research. Therefore, responses from those outside this branch were removed from the database. This leaves 167 valid and usable responses in the database. In order for the quantitative data to be used to back up statements from the interviews and conversations, quantitative data analysis is performed by calculating different descriptive statistics and conducting different tests of interesting topics. With the use of the statistical program SPSS different descriptive statistics were calculated and tests were done. These statistics involve frequencies and percentages of, for instance, staffing levels, work-life balance, and influence on health. Additionally, one simple linear regression analysis was performed, with this test it was analyzed whether the perceived value of different actors has a significant effect on overall well-being of healthcare personnel, and how big this relationship is. Two more One-way ANOVA tests were conducted to look for interesting connections between the variables of perceived usefulness of organizational and technological innovations, and job satisfaction. The statistical data that was gathered by this quantitative analysis is linked to the different themes that emerged from the analysis of the interviews and conversations, in order for it to back up these statements.

The mixed-methods approach of this thesis is most suitable for the researched topic at hand, as it allows for a comprehensive and multifaceted analysis. The qualitative data from the interviews and conversations provides in-depth and personal insights about the experiences of nurses and other healthcare professionals in their daily work practices, highlighting certain stories or nuances that cannot be expressed in numerical data alone. Meanwhile, the use of quantitative data also gives the opportunity to identify broader patterns and trends, by which certain statements and experiences can be more generalized. It can show that more or most nurses and carers experience their work in the way that they do. By combining both approaches, this study gives both depth and breadth, validating qualitative insights with statistical data gives a more overarching understanding of healthcare workers' experiences. With this mixed method approach the reliability and applicability of the findings are enhanced, making the results more relevant and usable for improvements and policy recommendations in the healthcare sector.

Ethical Considerations

The topic of this research might be a rather sensitive subject for some interviewees, which makes some information difficult to share. As they do not want to be negative about their employer or function, this

could lead to a limitation to the research. As they might not want to be interviewed, or they will not say everything they want or think. To avoid part of this limitation, complete anonymity is guaranteed to the people who are interviewed and who fill in the survey, and it must be made clear that their vulnerable position has been considered and will not be breached. Furthermore, all participants of the research know the purpose and benefits of participating in the interviews and surveys, and they are given informed consent. Next to that, complete confidentiality is assured, all identifiable information about them from the interviews or surveys is not used in the report and is deleted. Finally, participants of the survey are free to stop filling out the questionnaire at any point, for any reason, as not to pressure people into answering questions about certain themes they do not feel comfortable with.

Impact on Systems in Elderly Homes

This chapter gives a contextual overview of elderly care and homes in the Netherlands, while also addressing the processes and issues currently affecting the professionals working within it. By examining how different systems within elderly homes function, and how they are impacted by undervaluation, this chapter tries to answer the research question: *How is the functioning of different systems within Dutch elderly homes impacted (e.g., staffing, resource allocation)?* The analysis draws upon interviews with care personnel, managers, and labor union representatives, as well as insights from the questionnaire.

Nursing Homes in the Netherlands

Dutch elderly homes play a crucial role in providing long-term support to the aging population of the country, who have increasingly more complex care needs. Elderly homes are at the center of providing this care, relying on several organizations, structures of staffing, and organizational policies to ensure high-quality care for these people. However, for a long time, the sector has faced growing challenges in providing this care, and for the people working in it, ranging from structural staff shortages and budgetary constraints to rising workloads, which significantly impact the well-being of healthcare professionals and the way the nursing homes run. One visible consequence of these growing pressures is the high rate of absenteeism among healthcare workers. In October 2021, absenteeism in the Dutch healthcare reached a record high of 7.6%, with the VVT (Dutch abbreviation for nursing homes, care homes, and at-home care) facing the highest rates at 8.7%. By December 2021, an estimated amount of 100,000 healthcare workers were absent due to illness (Bohn Stafleu van Loghum, 2022).

To understand how care and its delivery are organized within these strained conditions, it is important to examine how nursing homes operate within the broader Dutch healthcare system. The collective labor agreement of the VVT defines a nursing home as a private legal entity (with or without a profit motive). This entity manages one of several institutions where stay with care is offered, under the conditions of having the repeatedly insured package of long-term care. This care includes providing food and drink, cleaning the living space, providing aids and facilities, and at least personal care, guidance, nursing, and treatment of geriatric rehabilitation care. The care is mainly aimed at clients with somatic or psychogeriatric conditions and can be provided both intramurally (stay in an institution) and extramurally (care for patients living independently, including assisted living or clustered homes) (CAO VVT, 2024).

Dutch nursing homes can either be private or public, the latter being the majority of the homes. The budget within these homes is organized in a complex way. The nursing homes receive their budget via the Long-term Care act (Wlz). The government in The Hague distributes the available budget for the care sector among the care offices, such as CZ or Zilveren Kruis. These care offices then distribute budgets for care organizations, based on the care indications of their residents. The indications are determined by the CIZ (Centre for Care Indication) and are linked to the ZZPs (Care Intensity Packages) of the residents, which determine how much and what type of care someone needs. Each package represents a certain amount, with which all care and support costs of that resident must be covered. An annual budget is drawn up within the homes, in which it is recorded per location what money is spent on, e.g., personnel costs, facilities, and care costs. The size of the budget per location depends on the number of residents and their associated ZZPs.

For years, there have been cutbacks in healthcare by the Dutch government. Leading to, for instance, few resources for equipment, and the closing of several homes. Which are now so much needed with

the increase of the elderly population, they are now forced to stay longer at home and depend much on informal family care, and at-home care by nurses. The government arranges the budgets that are there for healthcare, but politics have little to no idea of what goes on in the healthcare sector. When a caregiver expressed his stance on this, he said the following: *“I don't feel like that those who we have to stand up for care, stand up for care [...] Most of them hear those stories [...] Have they really gone to look? Go see yourself and really show that you understand what's going on [...] Come along for a day [...] I don't have the idea that the government really knows what's going on.”* Not only does the government influence the budget, but it has a big influence on the labor market as well. A lobbyist of the labor union states that the government also has a very large influence on the education for care personnel and its attractiveness: *“How attractive do you make it to do a certain education? Are there enough education options? Are there enough teachers? What about internship compensation?”* Making education to become a caregiver or nurse more attractive could help with the declining labor market for these employees.

Every elderly care home's management and Human Resources of those organizations must adhere to a collective labor agreement (CAO in Dutch), containing agreements valid for 2 years, which are negotiated by negotiators from the labor unions representing the care workers (like NU'91) and negotiators for the employers. These CAOs are there to ensure the employees are protected and make sure everyone is treated the same and in a good way. The agreements outline employment terms for nurses, including their wages, job responsibilities, and working conditions. Wage structures are established based on function classification systems (FWG), ensuring nurses are compensated according to their role and experience in the care sector. Wages increase annually through a system of periodic raises, and promotions can be made when the employees achieve more qualifications or education. Next to the wages, the CAO also defines the coverage of the nurses' work, work hours, rest periods, and rights such as free weekends and the ability to influence their own schedules. The agreements made in the CAO are binding and ensure all nurses get treated the same across the institution, but also across the Netherlands. Through these types of agreements labor unions advocate for the professional and financial recognition of nurses' work in the healthcare sector.

Impact in Nursing Homes

Undervaluation is felt by healthcare professionals by the government, society, management, and their superiors. This all influences their daily work practices in different ways. Many of these problems originate from the long-standing undervaluation of care work, which has led to many budget cuts over the years. These external influences and decisions, such as limited representation in policy, lack of societal recognition, and the cutbacks, directly have their effect on the structural problems on the work floor. When care work is undervalued at the policy level, it leads to fewer resources, understaffing, and all the additional consequences.

Following rounds of budget cuts, the elderly care sector had significant staff reductions due to decreased funding for personnel, along with a decline in job opportunities, making careers in healthcare less attractive to newcomers. As a result, fewer people pursued education and training in this sector. Today, the sector is facing severe staffing shortages, and the long-term consequences of those earlier policy decisions are being felt throughout the healthcare system. The shortages not only increase the workload and strain on existing staff but also affect the quality and continuity of care for residents. Moreover, the public image and current working conditions in healthcare do little to attract new professionals to the profession, while existing nurses leave the profession due to the persistent high pressure, lack of recognition, and poor working conditions.

The interviews reveal that the biggest issues nurses and carers face in their daily work practices are the shortages, problems with schedules, vacation days that cannot be taken, and high work pressure. These issues are outcomes of the systemic neglect, when governmental policies fail to account for the rising demand in care, it leads to a heavier workload for fewer workers. Just like the social undervaluation, which makes it harder to attract new professionals, increasing the shortages. Additionally, the increasing demand for care, due to the greying population in the Netherlands, further intensifies these difficulties in the care sector, and asks for innovation and new ways to organize the work. The shortages being one of the main issues faced today in elderly care.

When looking at the data of the questionnaire, only 27.0% of respondents indicate that there is always or almost always enough staffing in their teams to provide good care. The majority, 38.9%, feel like the occupancy of their time is sometimes sufficient, and sometimes not. 34.2% of the respondents usually do not or never have enough staffing in their team to provide good care (see table 2). From the interviews, however, it should be noted that the staffing and shortages really diver per organization and even between teams. Some interviewees from one organization said that they have lots of problems with filling the schedules, and other interviewees of another organization feel like they have sufficient employees in their teams to always be with enough people.

Table 2. Staffing level in teams.

	Frequency	Percent
yes always	7	4.2
usually yes	38	22.8
sometimes yes, sometimes no	65	38.9
usually not	28	16.8
no, not at all	29	17.4
Total	167	100.0

Within the organizations of elderly care there is a structural shortage of healthcare professionals, which has an impact on the daily care processes within the homes. Due to a declining inflow of qualified nurses and carers and a decrease in permanent staff, the stability for colleagues, but also residents, is under pressure. According to several interviewees, there are often only two or three permanent employees per day working in a team, while the rest of the team consists of flex workers or self-employed personnel. This lack of stability creates organizational challenges but also impacts the team feeling and spirit. The care that these employees can deliver therefore, does not go beyond the bare minimum at times, because there are simply too few people on the work floor. A nurse facing a lot of issues with sufficient employees in her team states how: *"I think the minimum can be offered. Everyone survives, but I think we could offer much better care with more stability."* Due to staff shortages, it sometimes even occurs that residents cannot be brought to the toilet in time, showing how basic care is coming under pressure.

Due to the shortages, some healthcare organizations indicate that they can hardly manage to fill the schedules, which is mainly felt by the employees. *"Many organizations are currently at their wits' end; they cannot manage to complete the schedules."* Although many hope for better times, working with 'gaps' in the schedule has now become the new norm, with many consequences for the experienced work pressure, quality of care, and job satisfaction. A lobbyist of the labor union puts how: *"fewer and fewer people are motivated to enter healthcare. That is really decreasing and that is a real problem. Also, because it is so negatively portrayed in the media."* The shortages affect the schedules and (mandatory) vacation days of the employees. Many changes are made in the schedules, and people get called back when they requested holiday or days off.

An example illustrating how big the shortage problem actually is in the homes is when the interviewed managers talked about how in the past year nursing homes had money left over at the end of the year. This may sound like a positive thing, but this is actually caused by the lack of staff and all the gaps in the schedule, leaving the homes with money that was set aside for salaries. Which in the case of the interviewees was fortunately paid out to them as a bonus or invested in renewals and innovations. There have also been frequent bed-stops, meaning that for one or two months no new people were admitted to the homes, because the pressure became so high on the understaffed teams that they could not make ends meet. These stops are put in place to first get the team back in order and take the pressure off for a while, and then when they are confident again, to scale up.

As a solution to the tight labor market, there is an increase in lateral entrants, however the interviewees highlight that this often leads to qualitative difference within the teams. These new employees do not follow a regular 4-year nursing education and sometimes lack the professional feeling or experience needed to immediately reduce pressure in the team, it takes a longer time. Moreover, there are signals that students and interns who could potentially fill part of the staff shortages, also feel that they are not taken seriously enough at times. Their potential is not being optimally used, and it discourages some to continue with their education.

Due to the structural undervaluation of care personnel and the persisting staff shortages (as discussed above), many nurses and caregivers experience very high work pressure in their work. The higher the shortage of qualified personnel, the higher the burden gets on the employees who are left over. A comment on the questionnaire adds to that by stating how as a result of minimal staffing everyone has become accustomed to working very hard, but that it is not a sustainable situation. Work pressure is heightened due to other processes as well, changing care for the greying population, and an increase of (technical) innovations.

A big sticking point for care workers is the struggle with the high load of administrative tasks, which takes up much of their time. They have the feeling that they constantly have to perform more administrative tasks, often caused by technological systems and an increase of bureaucratic procedures, which do not always contribute to efficiency. For instance, they have to report everything they do in registration systems for colleagues to read, and for the families of the residents as well. As one nurse states: *“Administration is really a lot of work [...] you just have to keep recording a lot, also to prevent things and also for family so that they can read along.”* This increased registration pressure leads to less time left for direct patient care or to do something extra for a resident. At the same time, care itself is becoming more complex, clients stay at home longer and are only admitted in a nursing home when they need high and intensive care and have already multiple diseases at the same time. While there is not always sufficient staff with the right qualifications to provide this care, which heightens the work pressure for all the employees in the elderly homes. The workload and pressure are therefore not only a consequence of the undervaluation, but it also has large consequences for the nurses themselves and their well-being.

Other work practices are also affected by the shortages and heightened work pressure. Such as time allocation and task prioritization in their daily work practices. Due to the shortages and gaps in the schedule, nurses and caregivers are often forced to prioritize only doing the most essential tasks, such as doing medicine rounds, assisting with basic hygiene, and responding to emergencies. This limits time available for social care and meaningful interactions with residents, which is very crucial for their well-being. Lack of such interaction can negatively affect their behavior and emotional state, especially those who deal with chronic and progressive brain disorders (like dementia or Alzheimer). Many caregivers express frustration at not being able to offer more than the bare minimum sometimes. The shortages also

affect the training of new staff, interns frequently lack proper supervision due to time constraints, leaving them feeling unsupported, which does not help with their development into the medical field. As there is no time or space to train newcomers, they often are not informed well enough of how everything works and who is who. This can then also put additional pressure on the staff who were already there, who are expected to fill in or correct mistakes. In response to the ongoing shortages, some elderly care organizations experiment with new ways of working. Task redistribution, for example, is becoming more common to make time free for nursing tasks, by letting the supporting staff take care of non-care tasks. While these innovations could work, they also require time, training, and change from within, which can be difficult to achieve in these times of high pressure.

This chapter has shown how the functioning of different systems within Dutch elderly homes is significantly impacted by undervaluation of care work and the broader structural and political dynamics. The undervaluation of care work at a societal and financial level leads to, amongst others, a substandard salary (compared to other professions), and staff shortages. These external pressures result in internal consequences, mainly in the way of unstable staffing and an increased workload. In addition, nurses and caregivers face an increasing number of administrative tasks and a lack of time for meaningful interactions with their residents, which has a negative effect on both the care personnel and the residents' well-being and quality of care. And while some organizations are attempting some organizational innovations, the success is still often limited, and there are still big consequences on the mental and physical well-being of the nurses and caregivers.

Consequences for Healthcare Personnel Well-being

This chapter explores the consequences and effects of undervaluation on the well-being and professional satisfaction of healthcare personnel working in Dutch elderly homes, focusing on both their well-being and professional satisfaction. The analysis is based on survey data (N=167), informal conversation topics, and selected interview quotes and intel, which show the personal experiences and statistical trends coming with this topic. The analysis highlights how personnel’s well-being is influenced by various factors, including the balance between work and private life, the level of work pressure experienced, autonomy, and the perceived value of their function and healthcare in general. All these elements have an impact on the professional satisfaction with their work, and on the health of healthcare professionals, both mentally and physically.

Work-Private Life Balance

A first factor that influences the well-being of healthcare personnel is the balance between work and private life. Working in the elderly care sector demands a lot from its employees. Nurses and caregivers state how they have the feeling that they are constantly available and reachable, and are often asked to cover extra shifts, and their days off are regularly cancelled, due to problems with scheduling. Even when they are free, many find it difficult to say no when asked to fill in, especially when there is a shortage of staffing. They would want others to come as well when they are in need. As a result, they put private plans aside, and there is little room for resting and recovering: *“You are reachable, and you are still always on standby. You are never really at rest.”*

This statement highlights the feeling of constantly being available for your colleagues and managers. There is a big responsibility feeling amongst nurses and carers, which they feel towards their clients and colleagues, which weighs heavily. This often leads to work being taken home, both literally and mentally. For nurses and caregivers just starting, it is even more difficult to distance themselves from the pressure and responsibility: *“I notice now that I am getting a bit older, that it is easier for me to get rid of it. But especially when I had just finished my training and was still finding my place as a nurse, and the pressure you felt as a nurse [...] I took that home with me.”* So, while she was at home, she was still working and thinking about her work. Due to the shortages of colleagues and sometimes difficult working conditions, the constant pressure causes problems and stress in private life as well, which also reinforces the experiences at work. When you are stressed at work, you vent at home, which does not make it any more pleasant at home. One of the interviewees highlights how: *“Many people are reaching their limit.”* When looking at the respondents of the questionnaire, this is confirmed, balancing work with private life proves to be difficult for many healthcare professionals. Over 40% indicates that maintaining this balance is difficult or very difficult (table 3), while only 28.4% experience it as good or very good. This all makes it clear that the disturbed work-life balance caused by the structural problems in elderly care has direct consequences on the well-being of care workers.

Table 3. Work-life balance.

	Frequency	Percent
Very good	3	1.8
Good	45	26.6
Neutral	47	27.8
Difficult	62	36.7
Very difficult	10	5.9
Total	167	100.0

Value

Value and feeling valued in doing your job impacts the way in which you experience your work and has an effect on your well-being. No one feels good doing work nobody recognizes or values. Value thus plays a large role in the well-being and work happiness of employees in the elderly care. For many, the real value of the job comes from the gratitude of clients and their families: *“I get the appreciation mostly from the clients. That is also why I do this work.”* When the residents feel safe and seen, it gives employees a sense of purpose and maybe even satisfaction: *“I really enjoy taking care of someone, and that someone feels safe with you. That always outweighs all the negative.”*

However, this intrinsic motivation of the nurses and carers is often not supported with valuation given by managers, organizations, or society. They often feel unseen and not taken seriously, leading to frustration and the feeling that their efforts are taken for granted. There is an overall consensus among healthcare employees that their work is hard and complex (especially in recent years), more than the public and sometimes even the management realizes. Social perceptions, biases, and stigmas reinforce this social undervaluation. As one nurse explained in an interview: *“Everyone thinks you're just washing some butts, handing out some medicine. But there is a lot more involved. Much more than you'd think. And it is also harder than you'd think.”*

The lack of recognition, especially accompanied by the structurally lower wages, as compared to other professions, affects the self-esteem and well-being of the healthcare professionals. As one interviewee noted: *“Employees really do feel taken for granted.”* Interestingly, the financial value and pay nurses receive is generally seen as okay, or maybe more as something they have accepted that comes with the profession. And while financial reward is important, many nurses state that feeling valued is primarily about being seen and heard, having a say, and experiencing respect for the work that you are doing. A lobbyist of the labor union says that: *“In general, the problems they have are often not about the salary, but the appreciation they get. Whether they are valued, whether they are heard, yes or no.”* When they do not get valued in that way, the balance between giving and receiving gets lost, and job satisfaction can decrease, despite the love for caring itself.

Value impacts the well-being of the employees in the elderly care. To see in which way value impacts the well-being of healthcare professionals, a statistical test was performed with the data of the questionnaire. The outcomes from questions 11, 12, and 13 from the questionnaire were combined into one variable: Overall Well-being. To look for interesting connections, it was tested whether the overall well-being of healthcare professionals is significantly influenced by their overall perceived value (mean of different perceived values per actor of question 17). From the simple linear regression, it becomes apparent that the perceived value has a significant impact on the overall well-being.

Table 4. Effect of perceived value on well-being.

		Unstandardized coefficients		Standardized coefficients		
Model		B	Std. error	Beta	t	Sig.
1	Constant	4.434	.174		25.434	.000
	Value	-.023	.003	-.513	-7.649	.000

Note. DV = Mental, Physical Health & Overall Well-being. Higher well-being values indicate poorer outcomes.

A simple linear regression analysis was conducted to examine whether the perceived value (independent variable, 0 = lowest, 100 = highest) significantly predicted participants' overall well-being, including

mental and physical health (dependent variable, 1 = good, 5 = bad). The results (see table 4) show a statistically significant negative relationship between perceived value and well-being, $B = -0.023$, $SE = 0.003$, $t(164) = -7.65$, $p < 0.001$. The regression model was significant, $F(1, 164) = 58.51$, $p < 0.001$, and explained 26.3% of the variance in well-being scores (as $R^2 = 0.263$). The standardized regression coefficient ($\beta = -0.513$) indicates a strong negative effect. Since higher well-being is indicated by lower scores on the scale of the variable (1 = very good, 5 = very bad), this negative association suggests that higher perceived value is linked to a better overall well-being of healthcare professionals. In other words, healthcare professionals who feel more valued by their residents, colleagues, supervisors, management, and government as high, have a better overall well-being within the care institution and in their life.

Mental and Physical Health

The factors of shortages, work pressure, undervaluation, and disturbance of work-life balance have an impact on mental and physical health of the nurses and carers in the elderly care. A significant number of healthcare professionals report mental health challenges related to their work. According to the questionnaire, 45.2% of respondents experience stress or mental exhaustion often or always, while an additional 42.8% report feeling this sometimes in their work (see table 5). The work of nurses demands a lot of them, both mentally and physically, often more than is healthy for them.

Table 5. Experience of stress and mental exhaustion.

	Frequency	Percent
Never	2	1.2
Rarely	18	10.8
Sometimes	71	42.8
Often	68	41.0
Always	7	4.2
Total	166	100.0

Care workers structurally put themselves last, and just keep going, sometimes at the expense of themselves and their health. A lawyer who deals with these kinds of issues every day sees how nurses: *“put themselves last, they do not give sufficient priority to their own health and well-being. And then there is the risk that you are taking a toll on your own health. Either physically or mentally, perhaps both.”* Due to this attitude, combined with high work pressure, staff shortages, and little room to set limits, many mental complaints and issues like stress, fatigue, and burnout are reported. These cases are no exceptions, and every interviewee said that this happens frequently in care organizations. One interviewee even commented how she fears that in the current healthcare system: *“One day you come home yourself and you are burned out. You are completely exhausted.”*

This mental pressure often affects the physical body as well, meaning physical complaints are widespread throughout nursing homes. A nurse states how she gets a lot of: *“fatigue from stress, sleeping badly. If you have the early shift you start to worry the night before. That sometimes makes me so tired.”* From the questionnaire, it can be seen how 62.1% of the respondents report a large to very large impact on their physical health (table 6). From the data, however, it is noticeable how most people with physical problems are people who have worked for a long time in the healthcare industry.

Healthcare employees experience sleep problems, lots of worrying, and exhaustion that comes out in a physical way. Next to that, due to the physical nature of the profession, a lot of physical complaints are present, such as back or shoulder problems caused by heavy lifting and long shifts. This can also have a mental impact. Especially amongst older employees, physical complaints pile up. A lobbyist for the

medical sector highlights how many older healthcare professionals put that: *“from 55+ it just all starts to decline [...] I am afraid I will not make it to the finish line.”*

Table 6. Influence on physical health.

	Frequency	Percent
No influence	2	1.2
Small influence	36	21.3
Neutral influence	24	14.2
Large influence	80	47.3
Very large influence	25	14.8
Total	167	100.0

In the team of one of the interviewed managers the absenteeism due to illness is 9%, which is a very high percentage when realizing she manages a team of 60 FTEs. Meaning the teams almost misses 6 full-timers. The absenteeism is often caused by an unstable home situation in combination with a high workload, which makes them ill, both mentally and physically. The interaction between mental and physical stress leads to a vicious cycle. *“Stress affects your body, and people then become ill, often for a long time [...] the people who are still there have to put in more effort, and they become exhausted as well.”* Even though there are nowadays aids that can partially relieve physical effort in the work, such as hoists for patients, this often does not compensate for the structural understaffing and high work pressure. Due to that, many care workers experience long-term physical strain, resulting in many sick days and absenteeism. The physically demanding work, combined with high turnover and aging clients requiring increasingly complex care, shows how the pressure of the work rarely ends at the end of a shift. It accumulates in the head and the body, and makes nurses exhausted, both literally and figuratively.

Professional Satisfaction

Despite the fact that many healthcare workers consider their work to be meaningful and valuable, their professional satisfaction can sometimes get under pressure due to the structural problems caused by undervaluation (as covered above). In many interviews, it came forward that choosing a profession in elderly care is often seen as a calling and something that must really fit you, in which the ‘caring heart’ (Dutch: *zorghart*) is central. This intrinsic drive, emphasized by a deep empathy and a desire to help and support others, often leads to healthcare workers prioritizing their commitment to the profession over initial financial compensation. While this intrinsic motivation gives that initial call for a career in the care sector, over time, the importance of fair compensation and recognition grows, especially when working under high work pressure for a long time.

From the research, it has become apparent that value and professional satisfaction for healthcare professionals is not just about the financial issue, do I get paid enough for the work I do and deliver, but also about autonomy, authority, and participation. Am I allowed to determine my own schedule? Why is someone else in control of how my work life is structured? A lack of say has a direct impact on the professional satisfaction of healthcare workers. The interviewed nurses and caregiver indicate that at times they do not feel heard or taken seriously by their management. A lobbyist for healthcare says how: *“they often feel unheard, the caregivers and nurses, because everything is kind of imposed on them from above. It is more ordered than done in agreement.”* Decisions are often made top-down without real input from the healthcare staff: *“It is dropped like ‘guys, this is what we are going to do’. We have this challenge ahead of use, and this is what it will be.”* And: *“people usually talk about the work floor,*

rather than with.” This creates a feeling that employees have the last priority within an organization, a lawyer daily dealing with various disputes of nurses says how they feel like they: *“are not taken seriously and have the last priority. That causes a lot of frustration.”* When this autonomy and authority are not guaranteed, it impacts the healthcare personnel on a personal level in different ways. Nurses quit their jobs when they feel they have too little say and too little autonomy, their work satisfaction is impacted, and their physical and mental health can be affected. In some organizations, a change is happening in which (policy) decisions are shifted from top-down to a more bottom-up approach, in which employees have a lot more to say and influence on what is happening.

The interviews show that when workers do experience influence, for example, on their schedules or work practices, their satisfaction increases significantly. A different lobbyist of the labor union puts: *“People want to have a say in their working hours and their schedules. That's really number one. It's often not about wages; people just want to have a schedule. One which get early enough, that fits in with their private life, and that doesn't change much anymore. And then when they have a say in that [...] then people are quickly satisfied.”* Autonomy in care practices also contributes to a sense of control over your own work and appreciation: *“If you feel unsafe or do not want to help certain patients, there should be room for that.”* Decision-making is therefore not only about participating in decision-making at a policy level, but also about daily practices and ensuring personal boundaries. Where management and teams work together and communication is balanced, the sense of involvement grows, *“then they have the idea we do it together [...] if the organization and employees do not work together, you get very unhappy employees.”* Thus, involvement in decision making (Dutch: zeggenschap) is of high importance when thinking about how people feel and experience their work. From the questionnaire, it becomes apparent that although almost half (48.5%) feel fairly or very involved in workplace decisions, over one-third (33.8%) feel little to no involvement (Table 7), which may limit professional autonomy and influence. Thus, more decision-making and autonomy can be an important key to strengthen motivation, job satisfaction, and well-being for the employees in the elderly care.

Table 7. Involvement in decisions.

	Frequency	Percent
Very involved	34	20.1
Fairly involved	48	28.4
Neutral	27	16.0
Hardly involved	52	30.8
Not involved at all	5	3.0
Total	166	100.0

One of the interviewed managers encourages ownership of her employees by actively and transparently informing them about everything that goes on within the organization. She structurally links developments back to the team, emphasizing how she always shares everything, so they have the opportunity to participate, and then always makes sure that if they want to participate there is room for it on the floor. By doing so, she makes it clear that employees are given the space and responsibility to think along and contribute. By making participation accessible and emphasizing the importance of involvement, employees feel they are taken seriously and encouraged to have an influence.

From the literature and research, it becomes clear that there is a tension between the intrinsic motivation of healthcare employees and the external appreciation they receive, which can affect the satisfaction of working in the elderly care. The constant feeling of pressure and feeling of limited influence and authority can cause a decrease in job satisfaction and more pressure on the quality of care. A nurse in

the elderly care puts: *“You just notice that the workload and management all have an effect on you personally [...] you go to work with less pleasure.”* However, many people still feel a strong sense of involvement and responsibility to their residents, to their colleagues, maybe even to their own ‘zorghart’. A nurse says how: *“I think that we really do this because our hearts are all in the right place, and we therefore want to deliver the best care for the client. If we do that together, you really do have a sense of solidarity. [...] Even if I don't have enough resources or whatever, you always make sure it works.”* The feeling of accomplishing something and helping someone’s day be a little bit better also fuels the satisfaction of care work. So, despite impact on the health of nurses, stress and systemic issues, the general job satisfaction for 50.3% of the responders is classified as being satisfied or very satisfied with their job (Table 8), and 59.1% are satisfied with the quality of care they can still provide (Table 9), even though they personally do not always feel well. Due to this dedication and resilience, despite the challenges, many nurses and carers still say with pride: *“It remains the best profession, even if it is undervalued.”*

Table 8. Satisfaction with work.

	Frequency	Percent
Very satisfied	17	10.1
Satisfied	68	40.2
Neutral	43	25.4
Dissatisfied	33	19.5
Very dissatisfied	6	3.6
Total	167	100.0

Table 9. Satisfaction with delivered care.

	Frequency	Percent
Very satisfied	20	11.8
Satisfied	80	47.3
Neutral	27	16.0
Dissatisfied	35	20.7
Very dissatisfied	4	2.4
Total	166	100.0

Overall Well-Being

As discussed above, interestingly, despite the challenges experienced by healthcare workers due to work pressure, in their work-life balance, on their mental and physical health, and their autonomy and authority, well-being is not low for healthcare employees. Surprisingly, 32.2% of respondents rate their well-being within the organization as good or very good, while 43.2% describe it as neutral (table 10). A respondent of the questionnaire puts: *“As long as I am not seriously hampered in my work by politics and management, I [...] have the best job in the world.”* This may suggest that job meaning, team support, or personal resilience buffers negative impacts for some of the healthcare professionals and still lets them feel good about their job at the end of the day.

Table 10. Overall well-being in organization.

	Frequency	Percent
Very good	2	1.2
Good	52	30.8
Neutral	73	43.2
Bad	37	21.9
Very bad	3	1.8
Total	167	100.0

That makes one wonder how care personnel validate and cope with their hardships in their daily experience of their work, and also in their personal life due to being a nurse or caregiver. It seems that the value they put on their work themselves, for what they do for their residents and the involved

families, helps them get through it. The intrinsic value of helping others, by making their days a bit better, apparently outweighs some of the bad and negative side effects the work and profession bring with it. So, despite the long hours, emotional and physical strain, the sense of the impact and connection remains a strong motivator to keep going. In fact, in some cases it can serve as a buffer against stress, burnout, and feelings of undervaluation.

The data and its analysis show that undervaluation within the Dutch elderly homes has clear consequences for the well-being of professionals, particularly in terms of mental stress, physical exhaustion, and work–life balance. Not every workday is a bad day, some days go by smoothly. But the hard days, the ones filled with stress, chaos, and gaps in the schedule, start to pile up. Over time, that weight accumulates and really starts to weigh down on the healthcare professionals and leaving a mark on their physical and mental well-being. Nevertheless, many caregivers remain committed and even satisfied with their work. This apparent contradiction can be explained by their deep sense of purpose and connection to the people they care for. Nurses and carers often find fulfillment and joy in knowing they have made someone’s day a little bit better. Despite the emotional and physical toll, the work often has, meaningful relationships with residents, feeling valued, and a sense of autonomy contribute significantly to both well-being and professional satisfaction. Yet, while many healthcare workers find joy in the care they provide, they also describe their days as heavy and challenging, often feeling like they are merely surviving within this strained and under-resourced system. These findings highlight not only their resilience but that even though they ‘survive’ within the system, there are a lot of changes that could help make their work sustainable and more bearable.

Navigating Challenges in Elderly Care

This chapter explores the way nurses, caregivers, and managers respond to the challenging conditions that their healthcare work entails. How do nurses and carers respond to certain conditions, have they found innovative ways to improve their work, are they offered help in certain challenging situations, and what do they try to implement to improve it. Furthermore, this chapter describes changes that need to happen within society to improve the work of nurses and caregivers. This chapter answers the research question: *How does the elderly care respond to the challenging conditions, and what should change?* The answer draws upon the data of the questionnaire (N=167), and the interviews with nurses managers, and labor union lobbyists, to come to an answer.

Within Homes

To try and navigate the challenging conditions within the elderly care, the organizations and also the nurses and caregivers themselves, try to find ways to cope with it. This can be either organizational innovations, the use of technological innovations, or changes in mentality and priorities of the employees.

Many organizations use technological innovations to try and make the work more durable for their employees. To reduce the workload of their employees, healthcare organizations collaborate with internal experts in the field of innovation. In one interview with a caregiver, an example of this came forward. In this particular organization, they have been experimenting with a system that alarms night-time restlessness among residents. Before, there were cameras installed that would give a notification based on heat and movement when a client got out of bed or walked out the door. These cameras often went off falsely or did not go off at all. This took a lot of time for the night nurses (who are often alone on a unit) as they had to walk up and down to different rooms to check on the residents, all night long. Now they have a system which consists of a sensor that is put underneath the mattress, which monitors very accurately whether a resident is out of bed, when they are sleeping, if they are restless, if they are waking up, or if they are already awake. This gives the night nurses a much better overview of what is happening in the rooms of the residents and saves them a lot of workload and time during their shift. Fewer rounds across the units need to be made, and more time for personal attention with the residents that are really awake is created by this. Across the different organizations there are a lot of examples like this that are being implemented to lessen some of the workload. Although the applications are still in development and not always immediately successful, organizations try to find ways to use technology in a natural and workable way within the daily work practices of the nursing homes.

From the questionnaire, however, comes forward how technological innovations could use a boost in their perceived usefulness for the healthcare workers (table 11). Of the respondents, 37.7% regards the use of technological innovations as (very) un-useful, while 35.3% do not really have an opinion about it, and a little bit more than a quarter (27%) of the respondents of the questionnaire regards the technical innovations as (very) useful. Further statistical testing between the perceived usefulness of technological innovations and satisfaction with work shows that the higher the perceived usefulness of these innovations is, the higher the work satisfaction becomes (see appendix 3, [table 13](#)). This shows the importance of matching technological innovations with the real needs and preferences of nurses. This could indicate that managers have to try to better consult their employees about what exactly their needs are, and what they would find useful in lessening their workload. Not only what they think could potentially work, but what really is needed and asked for on the floor. This also came back in the interviews. As one nurse expressed: *“It is determined from above. I don’t really have a say in it.”* Although ideas are sometimes ‘being discussed in management’, staff often feel they are only consulted

after implementation of a new innovation has already begun, which leaves little room for real influence and could limit the perceived usefulness and potential of the staff.

Table 11. Perceived usefulness technological innovations.

	Frequency	Percent
Very much	6	3.6
Much	39	23.4
Neutral	59	35.3
Little	52	31.1
Not at all	11	6.6
Total	167	100.0

Many organizations also use organizational innovations to try and make the work more durable for their employees. One of the interviewed managers explained an idea that she implemented in a new home she helped build and develop. This method is called ‘collaborators’ (Dutch: *samenwerkers*), it involves dividing all daily tasks, such as ADL (activities of daily living), basic care, cleaning, meal preparation, and organizing activities, among everyone who is working that day. By dividing the responsibilities across the team, more time becomes available for meaningful interactions and activities that can brighten the residents’ day. Each team member contributes to basic care, which not only lightens the overall workload but also enhances the well-being for staff and residents. Specialized care remains the responsibility of the nurses, but the remaining tasks are shared, encouraging a more balanced and collaborative working environment. Although this method has only been implemented for a short time now, it has proven to be effective in creating a good work atmosphere in the nursing home. It has to be noted however, that this method really needs to fit with you as a worker. Not everyone wants to help in the restaurant, or wants to do the cleaning as well, while others like the variety and flexibility this model offers. In essence, the collaborators approach promotes efficiency, teamwork, lower workload, and a resident centered care by breaking down rigid task divisions and encouraging shared responsibility and flexibility.

Another movement that came forward in an informal conversation was about reablement of the residents within nursing homes. This approach focuses on helping the elderly people regain or maintain, when safe and possible, their independence in daily activities. Instead of doing everything for them, healthcare workers encourage and support their residents to do as much as they can themselves. This shift in mindset is crucial, especially now that staff shortages are increasing the work pressure within the homes. Many nurses and caregivers are used to taking over tasks out of habit or care, but that is no longer sustainable. Reablement empowers residents, improves their well-being, and reduces their dependence on care staff. This eases the workload for caregivers and makes the day more efficient.

While such innovations as explained above could really help within nursing homes, the questionnaire reveals a significant disconnect between organizational innovations and their perceived usefulness by nurses and caregivers (table 12). Only 14.4% of the respondents regards the implementation or use of organizational innovations (very) much useful. 40.1% remain neutral, which could mean they are indifferent about it, or that there has not been much implementation of innovations in their organizations. Almost half of the respondents (45.5%) see it as (very) un-useful in their work. These results suggest that there is now a considerable gap between what is being implemented by management and what the staff actually need. At the same time, it could also indicate that there is a big potential for improvement, and there is room for more relevant and practical organizational innovations that could support the care professionals. Further statistical testing between the perceived usefulness of organizational innovations

and satisfaction with work, shows that higher perceived usefulness of these innovations is accompanied with greater job satisfaction (see appendix 3, [table 14](#)), highlighting even more how much potential lies there.

Table 12. Perceived usefulness organizational innovations.

	Frequency	Percent
Very much	1	0.6
Much	23	13.8
Neutral	67	40.1
Little	59	35.3
Not at all	17	10.2
Total	167	100.0

Nurses themselves also adapt to the sometimes challenging conditions in their workdays. Nurses often adapt to challenging working conditions by setting boundaries to protect both their own well-being and also the quality of care. One interviewed nurse described how he has learned to let go of tasks and set priorities when certain circumstances make it almost impossible to complete them: *“I nowadays refuse to work myself to the bone when it's such a hectic day and when no one cooperates, because that's not nice for the residents or for us. [...] If I don't finish everything so be it, I still have two people left for the night shift.”* He emphasizes that forcing care during these hectic moments is neither good for the residents nor sustainable for the caregiver. In this way, nurses develop their own coping strategies to deal with the pressure they experience, especially in demanding environments like closed units for heavy indicated residents. Another interviewed nurse copes with hard circumstances in her own way. *“As a person, I am someone who does not bottle up frustration but rather expresses it. I just have to get it out: I express it, vent my heart, and then I can go on. Sending helps me to release tension, and that's how you really learn to communicate openly with your team when things are not going well.”*

Another nurse explains how she, with her team, after proposing to and approval of their managers, implemented a very useful system to help deal with care pressure when they have a lot of gaps in the schedule or absent colleagues. She explains how they have *“a traffic light system, if we know in the morning, for example, that we have two sick people, we already have the list: well, this is what we're going to do, and this care we can leave out today.”* So, a green light would mean that the occupation and everything is as it should be, an orange light means there are gaps in the schedule, and less caring tasks can be performed. A red light means that there are big problems with staffing that day, and only the bare minimum, like wound care, and medicine rounds can be carried out that day. This helps with managing the expectations of the residents, and also their families, while releasing the pressure on the employees who have to carry the care of a whole unit with few people.

Within Society

In order to improve working conditions in healthcare, especially in nursing homes, there must happen a change on multiple levels within society, from governmental policy to societal attitudes. Within society, as described in the literature review, there are many stigmas and prejudices that lie on the profession of being a nurse or caregiver. These misconceptions often lead to a lack of appreciation and understanding of the complexity and emotional weight of the work. Nurses and caregivers do not just perform physical care and tasks; they also have emotional and complex responsibilities that are essential in providing good quality care.

In terms of national policy that is made by the Dutch government, all interviewed nurses say, to really improve circumstances in the elderly care or the healthcare in general, representatives of the government should come along for a day and really see and experience what is going on there. It is not that they only have to improve budgets for healthcare, but also help to make the study for nurses more attractive, and raise awareness about healthcare, which helps to release society from the stigmas that lie on it. Many nurses express frustration at the gap between what politicians say and what they actually do. One interviewee stated how he thinks that *“the role of caregiver and nurse is very negatively portrayed, even by politicians. As something that is not important, they claim that we are very important, but on the other hand they don't show it through the cuts that are in healthcare, and the market forces. [...] The real valuing is not there.”* There is a clear call for not just symbolic recognition, but also physical support and appreciation, such as better pay and improved education, to make the profession more attractive.

At the same time, societal expectations and perceptions must evolve. As one nurse explains: *“There has been a certain expectation from society for years about healthcare: we're paying for it, right? [...] So you just have to provide it.”* However, the reality of care today, with limited staffing and increasing demand, often makes these expectations unreachable and harmful. These unrealistic and outdated views and expectations often express itself in aggression from clients and families, which puts an additional strain on the nurses and carers. As another nurse puts it: *“You don't want to know what kind of aggression there is in our workplace today. From family, informal caregivers, and from the client, who expect a certain care to be given which is just not possible anymore. [...] So our first task is actually to bring all of society along with what is going on with care. And I think the government doesn't pay enough attention to that. [...] And it's not just about money, is about mindset and about expectations.”* In response to this, an interviewed manager emphasizes how expectation management is very important, because if people expect everything to be arranged for them within the nursing home and it is not lived up to, you do not get any appreciation from them from day one. Then they will only have something negative to say. This is understandable, because if you expect A and you get B, that disappoints people, resulting in negativity. Therefore, expectation management has to be tackled on a very large scale. If we only start doing expectation management when someone comes here and is already admitted and living here. Then it is already disappointing for them. Instead, it has to be clear before you even end up in a care home, this is what we can offer, and nothing more. With that in mind, if we want a durable and good healthcare system, for all people working and living in it, we must reconstruct the public perceptions of care work and recognize it not only as necessary, but also as something that is deeply valuable. As one interviewee puts it: *“I think something needs to change in our culture, that these kinds of essential professions need to become much more valuable in money and appreciation. At the end of the day, what do you really benefit from? Someone who in an office can calculate 1+1, or someone who can actually heal another person?”*

Discussion & Conclusion

The aim of this research was to find out in what way undervaluation affects healthcare personnel in their work practices, their mental and physical well-being, and professional satisfaction. How the ongoing undervaluation, both socially and financially, have caused these consequences, and what changes are or should be happening within the nursing homes themselves, and within society. This chapter will first summarize the main findings of the sub-research questions, while connecting it to the literature. Then the answer to the main research question will be given, and the chapter will conclude with this study's limitations, recommendations for future research, and a call for action.

Summary

The research and analysis of the data on the impact of undervaluation on the well-being of healthcare personnel and their professional satisfaction leads to the conclusion that healthcare personnel are significantly impacted on different levels within their work, but also in their personal life. Within the homes the systems of staffing and resource allocation are significantly impacted by the undervaluation of care work. As described in the literature, is this undervaluation not only financially underinvestment, but also from societal biases and thoughts, that care work is often viewed as low-skilled and naturally suited to women, reinforcing gender stereotypes and limiting (professional) recognition and pay (Aca et al., 2025; Glerean et al., 2017; Teresa-Morales et al., 2022). These assumptions and their effects are further deepened by neoliberal policies, which frame care as a private responsibility and have led to public funding cuts, contributing to care deficits and declined work conditions (Garnham, 2017; Tronto, 2013). These societal views continue to shape how the work of healthcare professionals is valued. External influences of social and financial undervaluation, and demographic processes of the aging of the population, affect the internal operations of the nursing homes. As a result, nurses and caregivers receive a substandard salary (as compared to other professions), there are very high staff shortages, a high workload, and policy decisions do not align with what is happening on the floor. There is an increasing number of administrative tasks and a lack of time for meaningful interactions with the residents.

The undervaluation of Dutch elderly care has large impacts on the nurses and caregivers working within it, it affects their well-being, especially through stress, exhaustion, and poor work-life balance. According to the questionnaire, 45.2% of respondents experience stress or mental exhaustion often or always, while an additional 42.8% report feeling this sometimes in their work. From the questionnaire, it can also be seen that 62.1% of the respondents report a large to very large impact on their physical health. These findings are in line with previous study that show how staff shortages increase workload, stress, burnout, and physical complaints amongst healthcare workers (Aiken et al., 2013; Rajbhandary & Basu, 2010). A lack of authority and autonomy, and appreciation further declines well-being and motivation (Bohn Stafleu van Loghum, 2012b; De Veer et al., 2012; Schlinkert & de Groot, 2023). Within the research, interviewees described a disconnect between management decisions and the realities on the floor, and expressed the need for more voice and involvement in shaping their work. Despite these mental and physical challenges, many caregivers expressed how they find strength in the meaning and impact of their work, and they remain committed and even still find professional satisfaction in their profession. This is largely due to a strong sense of purpose and connection with the residents they care for. Their intrinsic motivation and 'zorghart' play a key role in sustaining them. Meaningful relationships, feeling valued, and having some autonomy help the well-being of care workers. While the impacts on their health, stress, and systemic issues are big, 50.3% of respondents still report being satisfied or very satisfied with their job, and 59.1% are satisfied with the quality of care they are able to provide. Still, many describe their days as heavy and exhausting, often feeling like they

are just getting by in an under-resourced system, also reflected in the high absenteeism rates. As the literature stated that high stress levels contribute to absenteeism and reduced quality of care (Jennings, 2008; Rajbhandary & Basu, 2010). These findings highlight both the resilience of the healthcare professionals and the urgent need for changes to make their work more sustainable.

The elderly care sector is in need of innovations and a lot of change, from inside the organizations, but also from society. Organizational innovations could help with reducing the workload and work circumstances of the employees. However, there is still a big disconnect between organizational innovations and their perceived usefulness, this could use a big boost, and organizations should put more focus on this. There are also already a lot of technological innovations being implemented within organizations to reduce workload and create better circumstances for the nurses and caregivers to work in. But the results suggest that these technological innovations should only be implemented when there is a big demand for it from the staff and it aligns with what they really need and want. Otherwise, it will only be seen as another task that demands a lot of energy and time from them. Within society big changes have to be made as well. The Dutch government should connect more with healthcare, see what really goes on, and what is needed, and no more cutbacks on this essential part of society should be made. The government should also raise awareness in society, managing expectations, showing the complex work of nurses, and making the education more attractive.

To conclude this research, the answer to the central research question of this study can be given: *In what way has the undervaluation of healthcare in the Netherlands impacted the daily work practices, and well-being of healthcare personnel in Dutch elderly homes?* The undervaluation of healthcare in the Netherlands has significantly impacted both the daily work practices and well-being of healthcare personnel in Dutch elderly homes. There are severe staff shortages, high work pressure, unstable staffing, and rising administrative burdens, leaving little time for meaningful patient interaction. These conditions lead to high levels of mental and physical exhaustion, resulting in stress, burnout, and physical problems. Despite these challenges, many caregivers remain committed and enjoy their work, which is driven by a strong sense of purpose to care and connection with their residents. However, the underfunding and undervaluation of this system, combined with the disconnect between policy and practice, have left many nurses and caregivers feeling like they are just barely ‘surviving’. While technological and organizational innovations show potential for reducing work pressure, they must align with staff needs.

These findings contribute to broader academic debates on the valuation of care work, especially the tension between its essential societal role and the low social and economic status it holds in society. The findings highlight the resilience of care workers, who remain committed despite increasing pressure and limited recognition. At the same time, the research shows how care work is systemically undervalued and especially what the effects of this are, highlighting the urgent need to revalue healthcare, both within societal and political systems. Therefore, change is needed to ensure working in elderly care remains a sustainable profession for nurses and caregivers.

Limitations, Further Research, and Call for Action

This research poses some limitations of the design and concepts used, that may have affected the results. A limitation to this research could be that the participants for the interviews were recruited through purposive and snowball sampling, making use of existing networks and recommendations. As a result, the interviewed nurses, caregiver, and managers worked in two different care organizations, the interviewed labor union workers were all from the same organization. This may have influenced the variety of perspectives, particularly regarding experiences on the work floor, as the involved care

organizations could have represented workers with very positive or negative working environments. Nevertheless, the involvement of labor union representatives gave valuable insights into the structural and systemic issues and topics within elderly care. An additional limitation to consider is the potential for bias of the respondents of the questionnaire. There could be the case in which participants have only chosen to take part in the questionnaire because they have a strong opinion or negative experiences related to the topic at hand, which could have influenced the findings. Someone who is very satisfied with their job, or does not have any comments to make about it, will be less inclined to participate. This means that the data could overrepresent the negative stories, and underrepresent more neutral or positive experiences. While this does not invalidate the findings, it should be taken into consideration. Next to that, was this study aimed to explore the broad impact of undervaluation on the daily work practices and well-being of healthcare personnel, providing a strong picture of how undervaluation affects nurses in the Dutch elderly care sector. While this broad approach offers valuable insights into the interconnected challenges care workers face in their daily work, mental and physical health, and (potential) coping mechanisms and changes, it could have been explored more deeply by focusing on less different aspects. A final limitation of this study is that it did not account for how individual characteristics of participating healthcare professionals, such as gender, ethnicity, educational level, length of time working as nurse or caregiver, or contract type, influenced how they experience the effects of undervaluation. While the findings provide important insights, it does not reflect on personal differences that could be caused by some of these characteristics. Some groups can be affected differently than others.

Future research could include participants from a wider range of care organizations to gain a more balanced and comprehensive picture of how undervaluation is experienced by nurses across different settings on the work floor. Additionally, there is a big opportunity to focus more narrowly on specific aspects around this topic, such as only mental health, professional autonomy, or organizational innovations. This would allow for a more detailed and in-depth understanding of how undervaluation affects particular areas of nursing practice even more deeply. Furthermore, future research could explore how the effects of undervaluation in well-being, professional satisfaction, or coping mechanism differ per gender, background, or function. This would give more insight into how undervaluation of care is experienced across different groups within the elderly care sector. Finally, undervaluation affects not only the supply side of the healthcare sector and the daily work and personal lives of nurses, but also that of residents and their families who receive the care. An interesting opportunity for future research is to see how the undervaluation of care is regarded from the demand side, the residents living in the homes, and their families who support them. How do they notice the challenges, and how do they perceive the quality of care they receive?

Even though healthcare professionals are systemically undervalued in their work. They still love the job they are doing; they have a real heart for caring. Improving the lives or sometimes only a day of the elderly residents motivates them, even under hard conditions, to continue their work with much passion. And ultimately, care is a universal need, something everyone needs at some point in life. But how can we expect to provide quality care to the elderly or the ill if we fail to recognize, value, and care for the very people who deliver it: our nurses?

We, as a society, cannot continue to take advantage of the compassion of nurses and caregivers and their dedication to this profession by overloading them with this high pressure, emotional exhaustion, and unrealistic expectations, all while the consequences are already painfully clear. That is why, to prevent further deterioration of the elderly care system in the Netherlands and protect the nurses and caregivers working in it, urgent action is needed from both policymakers and the care institutions themselves. The government should recognize the real value care (work) has, and show this by stopping cutbacks, investing in sustainable staffing, and better working conditions. Organizational and technological

innovations should be expanded more, in close contact with the people working on the floor, ensuring that new methods and tools actually do ease the burden rather than add to it. Public awareness must be raised to fight the outdated and untrue stereotypes about care workers and promote its complexity and essential role within society. Only by truly valuing healthcare professionals, socially and financially, will elderly care remain workable, enjoyable, and resilient in the face of the growing demand.

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Appendix 1 – Thematic Framework Interviews

1.1 Interview Nurses and Carers

Introduction	Talking about what exactly is their role within healthcare. How long have you been working in healthcare? What does an average working day look like? What does the team look like? The composition of this team, if there are a lot of staff changes or vacancies, and whether this contributes to good and safe care. And about the access within the organization to resources such as tools, budget or training to ensure or even improve the quality of care.
Work-life balance	Do they ever have trouble combining work and private life? In what cases can that be seen? Do they ever get called up to fill in on their day off or during vacation? And how easy is it to actually take vacation days?
Authority and autonomy	To what extent do they have a say in their work? Are they involved in decisions about their own work and working conditions by management or supervisor? To what extent can they influence their own schedule or the way the work is organized? And where this could possibly be improved. The freedom to shape their own career in their own way, and whether certain forms of pressure can be recognized in this. More specific, whether they feel autonomy about making of their own schedule, distribution of work, quality of care, education and professional development, influencing policy of organization, and have a say in changes made on the work floor.
Mental and physical health	Whether they experience a lot of work pressure in their position? Whether stress and mental exhaustion sometimes play a role? Whether they sustain physical complaints from work. Whether they see this in colleagues. What the atmosphere in the team is like, and what can influence this? And how they would describe their general well-being within the organization.
Value	What does value actually mean to them? When do they feel valued in their work, and by whom? More specifically. Does the government really know what is going on in their work? What could they change? Does the management realize what is going on in the team and on the work floor, and what they could do differently? And how do they view appreciation within the collective labor agreement, are they financially sufficiently valued in their work?
(Professional) satisfaction	Are they satisfied with the work they do and the care they can provide? Would they recommend the work to others? What bottlenecks within a working day sometimes make their work difficult, administration, unnecessary tasks, lack of staff, insufficiently trained staff?
Coping mechanisms	How do they handle certain challenges of their work. Have they adjusted their way of working to cope with work pressure? Think about work pace, priorities, etc. To what extent do technological or organizational innovations help them make work easier or more efficient? Think client systems, lean work, or other new ways of working. Have they developed ways to cope with stress or pressure? And from whom do they seek support to manage moments when they feel undervalued?
Closing	And then finally, despite the challenges, what motivates them to continue working in healthcare?

1.2 Interview Managers

Introduction	What exactly does their job entail within healthcare? How did they get there? What does the team they manage look like, regarding staffing or problems? Do they feel the current staffing levels within the team are sufficient to provide good and safe care?
Policy	How are certain decisions about changes in policies and processes determined? How is budgeting arranged within the nursing home? Where does the money come from, how is it decided where to spend money, etc.? What kind of cuts are there? How do they experience this in the facility? How do they influence this?
Value	What exactly does appreciation and value mean to them? How do they make their employees feel valued in the work they do? And do they ever get complaints or stories about employees feeling underappreciated?
Authority and autonomy	How do they involve employees in decisions about their own work and working conditions within the organization? Are they involved in determining work schedules, training, quality of care, in policies, etc.? How do they ensure that people feel the freedom to decide how to manage their own careers? Are they offered opportunities, do they have to ask for them themselves? How do they encourage growth?
Mental and physical health	Would they say the workload is high within the team? Is there good staffing? Do they hear much about the impact of workload or other working conditions on the mental and physical condition of nurses? Is this something they hear more often within their team or in other organizations? Is there a lot of employee absenteeism within the team(s)? What are their complaints in particular? How is the atmosphere in the team perceived? How would they describe the general well-being in the healthcare facility? And how can this be improved?
Coping mechanisms	Do they push for certain modified ways of working to better cope with the challenges in the work environment? To what extent are they implementing technological or organizational innovations to make work more efficient and less stressful? Have they themselves come up with innovative ways to cope with the tightness within the healthcare industry? What, if any, are the results of this? Do they help their employees deal with workload and stress in certain ways?

1.3 Interview Lawyers

Introduction	What exactly does their work entail? Who do they speak to? How do they help these people?
Physical and mental health	What kind of signals do they get at the union about the mental and physical condition of healthcare professionals? There are many stories about healthcare workers being under high pressure. Is there frequent talk of burnout, stress or physical complaints? Are there certain groups within healthcare (e.g., nurses, caregivers) who are especially vulnerable?
Work pressure	Are there ever complaints about work pressure that come to them? Is it about structural overwork, no time for breaks, denied vacation time, are there reports

	where the work is so hard that people drop out or even leave? What role does the employer play in this, and where do things often go wrong?
Collective labor agreement	Another issue that comes back is that healthcare organizations do not always comply with collective bargaining agreements or job descriptions. Do they recognize this? Do they get reports of people having to do tasks that are actually outside their job description? What are the legal consequences of this? And what can an employee do? And if, for example, people work too many hours or structurally have no time for breaks or recuperation - what are their rights?
Value	A theme that often comes up in conversations with healthcare workers is the feeling of undervaluation. Do they recognize that image from their work at the union? In what ways does that lack of appreciation manifest itself according to the people they talk to?
Support	What support does the union offer when someone encounters these problems? Does it often come to legal action? How easy is it for a healthcare worker to make any of this at all? Or is there a lot of fear to speak up? What is their advice to caregivers who feel overburdened or notice that agreements are not being kept?

1.4 Interview Lobbyists for Nurses

Introduction	What exactly does their work entail? What kinds of places and institutions do they frequent? How do people come in contact with them? What kinds of topics do they talk about? What do they contribute for who they lobby for within the labor union?
Work pressure	What stories do they hear about care workers who are under a lot of pressure? What signals do they get about this when they go somewhere? Is it often about work pressure or also due to other causes? For example, is it about structural overwork, no time for breaks, taking vacation and then having to come back anyway? Are there stories about people where the work is so hard that people drop out or even leave? What role does the employer play in this, and where do things often go wrong?
Mental and physical health	What do they hear about personal complaints from healthcare professionals (physical and mental)? What signals do they get about this from the institutions they visit? Is there a lot of talk about burnout and/or stress? And about physical problems (such as physical complaints or fatigue)? Are there certain groups of employees within care (e.g., nurses, caretakers or aides) who are especially vulnerable or more often affected by these things than others?
Collective labor agreement	There are often cases where it comes back that healthcare facilities do not always comply with collective bargaining agreements or job descriptions. Are there employees who have to do tasks that are actually outside their job description?
Value	A theme that often comes up in conversations with healthcare professionals is the feeling of underappreciation. Do they recognize this from conversations with healthcare professionals? In what ways does this lack of appreciation manifest itself according to the people they talk to?
Financial value	How do employees view the value in salary they get? What are signs or stories they hear about that?
Authority and autonomy	Participation is also an important issue and something that is important to have as an employee. Do they ever hear that care staff lack this? And what are the consequences of that? Do employees feel that they are really being listened to, for

	example by managers or administrators? If not, how does that affect their motivation or confidence in the organization?
Policy and politics	How do they view the role of politics and policy in the problems they identify? Do they think national choices (such as budget cuts, regulations or staff shortages) have a visible impact on their daily work?
Succes stories	Are there places or institutions where things are going well? What is being done differently there, and what can other organizations learn from this? What gives them hope or energy in the conversations they have with care workers? Are there things they hear or see that make them think "this shows how strong and involved these people are"?

Appendix 2 – Questionnaire Outline

Ik ben Jelske, een masterstudent Sociale Geografie aan de Radboud Universiteit. Voor mijn master loop ik stage bij NU'91. Ik doe onderzoek naar de onderwaardering van de zorg en zorgprofessionals. Daarbij kijk ik naar hoe daaropvolgende bezuinigingen en andere maatregelen invloed hebben op zorgmedewerkers. Hierbij onderzoek ik:

- de manier waarop zorgpersoneel ondergewaardeerd wordt;
- wat voor invloed dat heeft het op de dagelijkse werkpraktijk;
- hoe het hen op een persoonlijk vlak beïnvloedt;
- hoe tevreden zijn zij met het werk dat ze doen en leveren;
- en op welke manieren ze proberen te navigeren op deze omstandigheden.

Om dit te onderzoeken, heb ik een enquête opgesteld. Deze bestaat uit 23 vragen, waarin de bovengenoemde thema's terugkeren. Het invullen duurt ongeveer 10-15 minuten en is volledig anoniem. Je gegevens komen nergens terug, zijn niet herleidbaar en worden niet verder benoemd. Alvast bedankt voor je tijd.

Via deze link krijg je toegang tot de enquête:

https://fmru.az1.qualtrics.com/jfe/form/SV_bknoX1jDEy1Somy

Introducerende vragen:

Door deze enquête in te vullen, ga je ermee akkoord dat je antwoorden gebruikt worden voor dit onderzoek. De data wordt alleen door mij gebruikt en alleen voor dit onderzoek. Je blijft anoniem en je hoeft geen persoonlijke gegevens in te vullen waar je jezelf niet fijn bij voelt. Het doel van dit onderzoek is om gegevens en informatie te verzamelen over de persoonlijke ervaringen van zorgpersoneel, met betrekking tot de manier waarop zij gewaardeerd worden en de daaruit voortvloeiende gevolgen.

Ga je hiermee akkoord?

- Ja
- Nee

1. Wat is je functie in de zorg?

- Helpende
- Verzorgende IG
- Verpleegkundige niveau 4
- Verpleegkundige niveau 5
- Woonbegeleider
- Begeleider
- Regieverpleegkundige
- Gespecialiseerd verpleegkundige
- Verpleegkundig specialist
- Operatieassistent
- Anesthesiemedewerker
- IC-verpleegkundige
- Ambulanceverpleegkundige
- SEH-verpleegkundige

- Student
 - Anders, namelijk
2. Hoe lang werk je al in de zorg?
- 0 – 2 jaar
 - 3 – 5 jaar
 - 6 – 10 jaar
 - 11 – 15 jaar
 - 15+ jaar
3. In welke branche van de zorg werk je?
- Geestelijke Gezondheidszorg
 - Gehandicaptenzorg
 - Kraamzorg
 - Universitair Medisch Centra
 - Verpleeg-, Verzorgingshuizen, en Thuiszorg
 - Ziekenhuizen
4. In welke regio ben je werkzaam?
- Drenthe
 - Flevoland
 - Friesland
 - Gelderland
 - Groningen
 - Limburg
 - Noord-Brabant
 - Noord-Holland
 - Overijssel
 - Utrecht
 - Zeeland
 - Zuid-Holland

Thema 1: Organisatie en beleid.

Thema 1 (organisatie en beleid) gaat over hoe het beleid en de organisatie van je werkomgeving aansluiten bij de praktijk op de werkvloer. Denk hierbij aan zaken als taakverdeling, personeelsbezetting, ondersteuning door het management en de beschikbaarheid van middelen om goede zorg te kunnen leveren.

5. Vind je dat de huidige organisatie van het werk (zoals administratieve taken en taakverdeling) aansluit op de werkomstandigheden op de werkvloer?
- Ja, helemaal
 - Ja, deels
 - Neutraal
 - Nee, niet echt
 - Nee, helemaal niet
6. Vind je dat de huidige personeelsbezetting in jouw organisatie voldoende is om goede en veilige zorg te kunnen bieden?
- Ja, altijd
 - Meestal wel
 - Soms wel, soms niet
 - Meestal niet

- Nee, helemaal niet
7. In hoeverre ondersteunt het management van de zorginstelling jouw belangen als zorgmedewerker?
- Volledig
 - In grote mate
 - Enigszins
 - In kleine mate
 - Helemaal niet
8. In hoeverre heb je voldoende toegang tot middelen (zoals budgetten, hulpmiddelen, trainingen) om de kwaliteit van zorg op peil te houden of te verbeteren?
- Volledig
 - In grote mate
 - Enigszins
 - In kleine mate
 - Helemaal niet

Thema 2: Welzijn van zorgpersoneel.

Thema 2 (welzijn van zorgpersoneel) focust zich op hoe zorgmedewerkers zich voelen in hun werk: fysiek, mentaal en emotioneel. Denk aan betrokkenheid bij beslissingen, werkdruk, stress, lichamelijke klachten en de balans tussen werk- en privéleven. Het gaat over hoe werkervaringen het algehele welzijn beïnvloeden.

9. In hoeverre voel jij je betrokken bij beslissingen over je eigen werk en werkomstandigheden?
- Zeer betrokken
 - Redelijk betrokken
 - Neutraal
 - Nauwelijks betrokken
 - Helemaal niet betrokken
10. In welke mate heeft jouw werk invloed op je fysieke gezondheid (bijv. vermoeidheid, lichamelijke klachten)?
- Geen invloed
 - Kleine invloed
 - Neutrale invloed
 - Grote invloed
 - Zeer grote invloed
11. Ervaar je wel eens stress of mentale uitputting door jouw werk in de zorg?
- Nooit
 - Zelden
 - Soms
 - Vaak
 - Altijd
12. In hoeverre lukt het om je werk- en privéleven in balans te houden?
- Zeer goed
 - Goed
 - Neutral
 - Moeilijk
 - Zeer moeilijk
13. Hoe zou je jouw algemene welzijn in jouw zorgorganisatie omschrijven?
- Zeer goed

- Goed
- Neutraal
- Slecht
- Zeer slecht

Thema 3: Kwaliteit van zorg en werkomgeving.

Thema 3 (kwaliteit van zorg en werkomgeving) gaat over hoe zorgmedewerkers de kwaliteit van de geleverde zorg en hun eigen werkervaring ervaren. Denk aan tevredenheid over de zorg die je kunt bieden, de omstandigheden waarin je werkt, je werkplezier en of je je gewaardeerd voelt voor je inzet.

14. In hoeverre ben je tevreden over de zorg die je aan de cliënten/patiënten/bewoners kunt geven?
- Zeer tevreden
 - Tevreden
 - Neutraal
 - Ontevreden
 - Zeer ontevreden
15. In hoeverre voel je jezelf in staat om kwalitatief goede zorg te leveren binnen de huidige werkomstandigheden?
- Altijd
 - Meestal wel
 - Soms wel, soms niet
 - Meestal niet
 - Nooit
16. Hoe tevreden ben je over je werk in de zorg?
- Zeer tevreden
 - Tevreden
 - Neutraal
 - Ontevreden
 - Zeer ontevreden
17. In hoeverre voel je je gewaardeerd voor jouw inzet en bijdrage aan de zorg? (0 = helemaal niet gewaardeerd, 100 = zeer gewaardeerd). Door:
- Cliënten/patiënten/bewoners
0-----100
 - Collega's
0-----100
 - Leidinggevenden
0-----100
 - Bestuurders
0-----100
 - (Landelijke) politiek/regering
0-----100

Thema 4: navigatie- en responsstrategieën.

Thema 4 (navigatie- en responsstrategieën) richt zich op hoe zorgmedewerkers omgaan met de uitdagingen in hun werk. Denk aan het aanpassen van je werkwijze, het inzetten van technologische of organisatorische innovaties, omgaan met werkdruk en het zoeken van steun.

18. Heb jij je manier van werken aangepast om beter om te gaan met de uitdagingen in jouw werkomgeving? *(Meerdere antwoorden mogelijk)*
- Ja, ik heb mijn werktempo of prioriteiten aangepast
 - Ja, ik vraag vaker om hulp of ondersteuning
 - Ja, ik neem bewuster rustmomenten
 - Nee, ik werk nog op dezelfde manier als altijd
 - Nee, maar ik zou dit graag willen doen
 - Anders, namelijk ...
19. In hoeverre helpen technologische innovaties (bijv. digitale dossiers, software) je om je werk efficiënter en minder belastend te maken?
- Zeer veel
 - Veel
 - Neutraal
 - Weinig
 - Helemaal niet
20. In hoeverre helpen organisatorische innovaties (bijv. nieuwe werkwijzen, Lean werken, zelforganiserende teams) jou om je werk efficiënter en minder belastend te maken?
- Zeer veel
 - Veel
 - Neutraal
 - Weinig
 - Helemaal niet
21. Welke strategieën pas je het meest toe om met werkdruk en stress om te gaan? *(Meerdere antwoorden mogelijk)*
- Pauzes nemen wanneer mogelijk
 - Ondersteuning zoeken bij collega's
 - Praten met leidinggevenden
 - Ontspanningstechnieken of sport
 - Geen specifieke strategieën
 - Anders, namelijk ...
22. Als je jezelf niet gewaardeerd voelt, bij wie zoek je dan steun? *(Meerdere antwoorden mogelijk)*
- Collega's
 - Leidinggevenden
 - Familie/vrienden
 - Vakbond of beroepsvereniging
 - Ik zoek geen steun.
 - Nog niet van toepassing.
 - Anders, namelijk ...
23. Wat motiveert jou, ondanks de uitdagingen, het meest om in de zorg te blijven werken? *(Meerdere antwoorden mogelijk)*
- De dankbaarheid van cliënten/patiënten/bewoners
 - De band met collega's
 - De voldoening van het helpen van anderen
 - De afwisseling en uitdaging in het werk
 - De mogelijkheid om echt een verschil te maken
 - Anders, namelijk: ...

Appendix 3 – Further Statistical Testing

A one-way ANOVA was conducted to examine the relationship between satisfaction with work in elderly care and perceived usefulness of technological innovations. The independent variable being the perceived usefulness of technological innovations, and the dependent variable being the satisfaction with work in the elderly care. The results show a significant difference between the groups, $F(4, 162) = 6.007$, $p < 0.001$. Post-hoc comparisons revealed that participants who felt technology supported them ‘much’ were significantly more satisfied with their work, than those who responded ‘little’ ($p = 0.006$) or ‘not at all’ ($p < 0.001$). Even those who responded ‘neutral’ reported higher satisfaction than the ‘not at all’ group ($p = 0.013$). These results suggest that better perceived usefulness of technological innovations, is positively associated with better job satisfaction in elderly care.

Table 13. Relationship between technological usefulness and satisfaction.

<i>Anova</i>					
	Sum of squares	df	Mean Square	F	Sig.
Between groups	22.414	4	5.604	6.007	.000
Within Groups	151.131	162	.933		
Total	173.545	166			

An additional one-way ANOVA was conducted to examine the relationship between satisfaction with work in elderly care and perceived usefulness of organizational innovations. In which the independent variable is the perceived usefulness of organizational innovations, and the dependent variable being the satisfaction with work in the elderly care. These results show a significant difference between the different groups of very much useful, and not useful at all, $F(4, 162) = 7.807$, $p < 0.001$. This suggests that higher perceived usefulness of organizational innovations is related to greater job satisfaction.

Table 14. Relationship between organizational usefulness and satisfaction.

<i>Anova</i>					
	Sum of squares	df	Mean Square	F	Sig.
Between groups	28.048	4	7.012	7.807	.000
Within Groups	145.497	162	.898		
Total	173.545	166			