

Care sharing between parents: the role of family care professionals. The Dutch situation in a European context

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1. Introduction¹

Over the last decades Dutch parents have begun to spend more time with their children. Mothers, however, still devote more than twice as much time to their children as fathers do (Gezinsrapport 2011). This gender inequality among Dutch parents with respect to parenting time reflects a more general European pattern: we can observe a widening gap between the ideal of equal parenting time on the one hand, and actual behaviour patterns on the other (Lück 2006). Ostensibly both men and women would like to achieve more equality in care duties than they actually manage in practice (Hobson & Fahlen 2009). At the same time, the bar of ‘good parenting’ is placed higher and higher (Cooke 1991). These discrepancies between actual and desired parental roles have important social consequences. They are related to gender inequalities in the marketplace (Sayer & Gornick 2011), declining birthrates (Mills *et al.* 2008), higher chances of divorce (Cooke 2004), and a growth in social and economic inequality between families (Blossfeld & Drobnič 2001).

In the last few years a great deal of attention has been paid in cross-national studies to care distribution within countries in relation to their welfare systems (Daly 2011; Fuwa 2004; Lewis 2009; Saracceno & Keek 2011; Knijn & Smit 2009; Knijn & Kremer 1997; Hobson & Fahlen 2009; Leitner 2003; Pfau-Effinger 2005; van Oorschot, Opielka & Pfau-Effinger 2008; Orloff 1993). It is often assumed that parents’ notions of gender and preferences are linked to social norms and existing institutions (Lewis *et al.* 2008; Sayer & Gornick 2011; van Oorschot *et al.* 2007). Social scientists have paid rather less attention, however, to how parental roles are shaped within individual contexts and the extent to which individual preferences are influenced by social norms. Continuing the trend of the recent literature, in which the rhetoric of ‘choice’ between working or caring for children is emphasized (Lewis *et al.* 2008), we examine the role of specialist knowledge - more specifically, medical expertise - as a framework within which parents make their choice. It is striking that previous studies have shown little interest in the relation between family policies at a national level and the professional domain².

In this article we examine whether family care professionals involved in prenatal and postnatal care influence the actual implementation of Dutch family policy. Drawing on interviews with family care professionals in this sector as well as direct observations, we illustrate how a combination of both perspectives yields a better understanding of motherhood and fatherhood in The Netherlands today. In particular, we aim to understand the prevailing situation in The Netherlands where mothers mostly work part time and fathers do so full time.

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² .Apart from Christiaens (2008), even though he homes in on the organisation of formal and informal care for mother and child and only examines the formal structures.

2. Methodology

This article concerns a review of the literature in which recent insights from the literature on gender and care in countries with welfare systems is combined with a review of the literature on medical expertise relating to care and the child healthcare sector during the years 1990 to 2012. This is done with a view to gaining greater understanding and insight into how parenting roles come to be defined and shaped in modern society. Alongside this we use semi-structured in-depth interviews set up as expert interviews (Bogner & Menz 2009), conducted in 2011 and 2012 during our ERC-research project³. A total of twenty family care professionals were approached having been selected from Dutch healthcare workers in the domain of pre- and postnatal care, namely midwives, children's nurses and paediatricians. We chose these professions because of our focus on the passage to parenthood: the professionals in question are involved with pregnancy and the first years after birth which puts them in a position to influence what parents know and do⁴. The selection of children's nurses and paediatricians involved in the postnatal stage took place because 92.8 % of Dutch children see these professionals in their consulting rooms in their first year of life (CBS 2010).

The interviews were transcribed and coded using Atlas.ti and the codes and interpretation were discussed both inside and outside of our research team in order to achieve the greatest reliability. Besides these interviews we also attended parent /clinician consultations. This participant observation (Hammersley & Atkinson 2007) had triangulation as its aim (Bryman 2008, 379) and was used to obtain an impression of what kind of parent the professional dealt with and how they applied the norms and expectations of parents in practice.

Recruiting the family care professionals involved using purposive sampling via contacts at the University of Amsterdam with the municipal health service (GCD). The GCD leadership looked into which teams were available for cooperation in our research. At our request variations in the socio-economic status and central urban location of the work areas were taken into account. The samples consisted of female family care professionals because all relevant teams consist of women and it is representative of child healthcare in The Netherlands (Lieburg 2001). The sample of family care professionals included variation in age, work experience and ethnic background. For the purposes of this article we used the first five interviews and the observations of eighteen office sessions of two paediatricians and sixteen office sessions plus two home visits of three child nurses. The work area concerns a region in the western part of The Netherlands (Randstad) with a mixed population from a socio-economic viewpoint. It is an area which has relatively few families that are low down on the socio-economic scale. Therefore the results used for this article are not representative of the whole of the Dutch population. Conversely, selecting parents of average-to-good socio-economic status has advantages because of our interest in a choice model. If choice exists, this is mainly the case for more privileged parents.

³ See also <http://apparent-project.com>.

⁴ For a focus on the period from pregnancy, see also Centre for Parenting Culture Studies 2011.

3. European welfare states and governance by expertise

Our study brings together two different strands of research in the domains of gender and care studies. The first one looks at the role of the welfare state and shows how, by means of it, more or less gender-specific work and care patterns were formed. This research suggests the value of a work and family policy that can make it easier for mothers to work as well as for fathers to perform caring tasks. However, it falls short in identifying the postponed reactions to certain policies such as fathers who do not take up paternity leave.

A second research tradition concerns the relation between the medical expertise of family workers and government attempts to manage parental behaviour ‘at a distance’ (Murphy 2003; Rose & Miller 1992). These studies argue that the opinions, choices and behaviour of both parents and family workers are framed by medical discourse. It is a discourse characterized by risk control, in which certain standards indicate what is ‘healthy’ and thus which behaviour is deemed legitimate (Knaak 2010; Murphy 2003, 2007; Rose & Miller 1992; Foucault 2000). This discourse is therefore normative. Rose and Miller (1992) emphasize normative matrixes because of their interest in political liberalism. We examine whether these concepts are also applicable to welfare state institutions in the broadest sense.

We have based our empirical research on the insights from both traditions and investigate the relevance of ‘governance at a distance’ by showing how normative knowledge and ideas about medical expertise and the Dutch ideal of shared parenting (Kremer 2007) are used by government and family care professionals in their approach to parents and children. Based on Rose and Miller (1992, 175) we define governance as “the historically constituted matrix within which are articulated all those dreams, schemes, strategies and manoeuvres of authorities that seek to shape the beliefs and conduct of others in desired directions by acting upon their will, their circumstances or their environment.”

3.1 Family policy and changes in work or care duties.

There is a general pattern of change discernable in European societies in the second half of the twentieth century. The most noticeable trend is the growing participation of mothers in the labour market. The stage of life devoted to home and family building has become shorter and the traditional model of the man as sole breadwinner and the woman as housewife is increasingly disappearing from modern societies (Blossfeld & Drobnič 2001). At government level the trend coincides with European policies focused on gender equality and the improvement of the fit between work and family life. During the last years, however, the emphasis on gender equality has moved into the shadows and attention has shifted to finding the right work-life balance seen from the perspective of the labour market. (Lewis et al. 2008; Knijn & Smit 2009). It seems that since the start of the new century, both for the EU and for its member states, it has been a focus on work that

has promoted the search for better family-work balance. At the same time, certain contradictions can be identified in this policy, resulting from the application of new labour market paradigms to a policy first developed with the model of the male breadwinner in mind (Lewis et al. 2008).

We are looking in this context at contradictions in Dutch family policy and its consequences for the freedom of choice fathers and mothers are supposed to have. In The Netherlands, women's participation in the labour market increased from the mid 1980s on. Seen from a European perspective, this is relatively late (OECD 2002). The increase in women's participation in the labour market was supported by the creation of a larger part-time professional work force⁵. In addition, the development has been facilitated through a shift in the Dutch policy from one which promoted an ideal of the full-time mother with the man as sole breadwinner, to an ideal based on shared parenting (Kremer 2007). During the 90s this ideal became dominant in Dutch policy in which part-time work for both parents and involvement of the father in child rearing was stimulated (Kremer 2007). An important marker in this policy is the individual right to parental leave, introduced in the early 1990s. In contrast to Sweden, Denmark and more recently Germany, the Dutch variant of individual parental leave does not offer financial incentives to fathers taking on care duties. Recent reforms in Dutch labour and family policies have focused more on equality of parents in the labour market than encouraging equality in parenthood. It is chiefly professional childcare, short parental leave and flexible working hours that have been promoted. In 2009 The Netherlands adapted its 'liberal' policies somewhat by compensating unpaid parental leave with tax breaks (Knijn & Smit 2009). This ruling hardly promotes equality of parenting, however. In 2009, 74 percent of women in the active population (15-64 years) were working in part-time employment compared to only 22 percent of men (Merens et al. 2011). This does mean that The Netherlands has the highest number of part-time workers in Europe (Siermann 2009). While mothers mostly work part-time to find a balance between work and care, fathers often work part-time for reasons other than child care (CBS 2012; Siermann 2009). In 2009, 41 percent of working mothers and 19 percent of fathers having right to parental leave actually made use of it (CBS 2011). Compared to other European countries, this percentage is particularly low (OECD 2011)⁶. Parents in full time work have a right to at least three months unpaid leave in the period before the child reaches eight years. In this respect The Netherlands does not meet the minimum criteria for leave suggested by Unicef (2008).

Currently no European country provides complete care coverage for a child's first three years of life but The Netherlands belongs to that group of countries in which the gap between the end of paid leave and the availability of daycare is widest (Saraceno & Keck 2011). The transition between these is best in Denmark, Sweden, Norway, Belgium and France (UNICEF 2008). In these countries the work options of parents and mothers with young children is supported by public policy, where various policy instruments hang together and show continuity. This also presents a different timing and balance between family care and (partial) de-familisation, in which families are unburdened of their care duties by professional help (Leitner 2003). The Netherlands, compared with these countries, makes the least use of daycare for children under three: less than 15 percent of children of this age spends more than 30 hours in daycare, compared to more than 60 percent in Sweden and 50 percent in Belgium (Saraceno & Keck 2011). The restricted

⁵ At the moment 60 percent of the female Dutch professional population works part-time, while the OECD average is 26 percent (OECD Employment Outlook 2010).

⁶ We refer to working parents who take leave for a child in its first year.

number of hours daycare use in The Netherlands reflects both a political strategy which leaves childcare primarily to the parents (Knijn & Smit 2009) and a historico-cultural distrust of professional childcare (Kremer 2007). Since the 1980s professional daycare, together with promoting work participation of both parents, is increasingly seen as a necessity but only for a limited number of hours per week (Singer 1996). Historically, The Netherlands has, like West Germany, a strong affinity with the model of a male breadwinner and the supporting of women in their roles as wives and stay-at-home mothers. The shift in policy towards one focused on the labour market and on individual responsibility for care (through the life events savings scheme, Lewis et al. 2008) goes institutionally against the grain of the Dutch shared parenting ideal as promoted in the 1990s.

Both the sudden emphasis on shared parenting and the labour market strategy oriented towards working couples marks a political re-orientation which branches off from mothers as principal carers for young children. During the last decades, attempts through policy in The Netherlands to obtain a balance between work and family has not followed a straight course. This is shown by the lack of government initiative in providing affordable childcare of high quality. Instead, such childcare is provided by private firms with government support in the form of subsidies or tax breaks (Lewis et al. 2008). Since 2012, however, childcare subsidies have been drastically cut again (Rijksoverheid 2011).

The absence of government involvement in childcare provision within the context of a policy viewing men and women as economically independent, leads to the reinforcement of gender differences (Lewis et al. 2008). A policy aimed at stimulating new ideas of shared parenting was thus implemented in a policy context originally designed for families made up of male breadwinners and stay-at-home mothers. Yet the division of care between fathers and mothers in The Netherlands is presented as a personal choice. It is unclear, given the high expectations from parenthood today, how many options new parents actually think they have in this context.

3.2. Family support workers: between government and workers

Rose and Miller (1992) attempt to deconstruct government influence into more understandable mechanisms and networks. According to them, the most important characteristic of modern governments is the ability 'to govern at a distance', whereby a government recognizes independent actors (such as doctors, parents, professionals and economists) and tries to manage them without destroying the autonomy of their activity. In this way the ideal of citizenship stays intact while families and individuals can be guided. This management can happen insofar as governments have contacts with non-political authorities, who in turn have contacts with citizens.

Likewise, we can see that the passage to parenthood in Dutch welfare society is steered by medical professionals who use (specific) discourse and knowledge as a form of governance and in this way create both matrixes and norms (van Teijlingen 2005). The role of medical family professionals in their contact with parents and children is only growing in importance because of the current trend to react quickly in times of risk (Lee et al. 2010; Hoffman 2010; Rouvoet 2007) and because of the increasing focus on children, social exclusion (Stouten et al. 2008) and developmental psychology (Thomas

2011; Hermanns 2009; Ansell 2005; Wubs 2004). That is why it is fruitful to study this professional sector in order to understand parental choices, since all parents increasingly experience interactions with these professionals at some point during their parenthood.

3.2.1 The organisation of pre- and postnatal care in Europe

Several studies have pointed to a process of medicalisation of childbirth (Brubaker & Dilloway 2009; Katz Rothman & Simonds 2005). In the USA and Canada, but also in Europe, the medical model is the most important matrix in which childbirth occurs (Brubaker & Dilloway 2009; Kateman & Herschderfer 2005; Christiaens 2008). In The Netherlands it is midwives who occupy a prominent position with a high percentage of home births. According to Christiaens (2008), this points to a situation of explicit familisation as opposed to de-familisation or optional familisation in other countries such as Belgium. Familisation emphasizes the family as primary care provider, whereas de-familisation emphasises the formalisation and delegation of care tasks to the state (Leitner 2003).

The organisation of preventive child healthcare in Europe has only recently been examined and mapped (Wieske et al. 2012; Speetjens, van der Linden & Goossens 2009; Stouten, van Gent & Gemmeke 2008). According to the research of Wieske and others (2012), all European countries signed the UN convention 'on the rights of the child' in which it is stated that each child in Europe has a right to the best available health care. Yet there are large differences in the healthcare situation of children in European countries, especially as far as child mortality is concerned. Preventive child healthcare, aimed at preventing illness and mortality among children, is organised differently in each country. In Belgium, Estonia, Finland, Hungary, Macedonia, The Netherlands, Russia and Slovenia, the target group in child healthcare includes all children between 0 and 19 years. Croatia provides care until adolescents gain their secondary school diploma, Switzerland until 16 years and Germany until 12 years. In each of these countries child healthcare is organised at a national level except for Germany where responsibility lies with both national, regional and local government. In most of the above-mentioned countries paediatricians and general practitioners play a central role, however, in The Netherlands and Belgium this role is allocated to specialised paediatricians, child nurses and multi-disciplinary systems. Preventive child healthcare is separate from medical treatment in these countries, except in Switzerland, Estonia and Slovenia. In all countries child healthcare workers keep records of provided care (Wieske et al. 2012).

Since the 1990s, policy and professional attention has been turned to educational support (Caris 1997; Clavero 2001; Stouten, van Gent & Gemmeke 2008). This has been ascribed to changes in family composition, increased attention to children as subjects of policy, and the fight against social exclusion (Stouten, van Gent & Gemmeke 2008). Policies targeting educational support are relatively new (ChildONEurope Secretariat 2007; Stouten, van Gent & Gemmeke 2008). There are large differences in the programs and methods offered in educational support. Some countries offer a comprehensive system of provision for all parents, whereas others specifically target families at risk and/or families with problems. All European countries generally have programs related to healthcare and focused on pregnancy and newborns. Fathers are more systematically

being involved in the first phases of having children (ChildONEurope Secretariat 2007; Stouten, van Gent & Gemmeke 2008).

This tendency can also be observed in The Netherlands. The consultation bureaus, first set up in 1901, were initially meant to reduce child mortality rates by focusing medical expertise on mother and child (Lieburg 2001). Between 2007 and 2011 the consultation bureaus were incorporated into 'Centres for Child and Family', financed by local councils (Rouvoet 2008; Samenwerken voor de jeugd 2011). These are low threshold walk-in centres in which variously specialized child healthcare workers and support staff can answer parents (to be), children and youngsters regarding questions of growing up, education, health and development. (Oudhof et al. 2010). Amsterdam uses the name 'Parent and Child Centre' instead (Nederlands Jeugd Instituut 2012). In both cases it is about speaking to parents regardless of gender.

The policy document 'Jeugd en Gezin 2007-11' (Child and family 2007-11) gives three guidelines for the running of these centres. The first proposition holds that the family plays an important role in education. The family here is defined in the apparently gender-neutral way as 'every household of one or more adults who have responsibility for the care and education of one or more children'. The second guideline concerns a 'turn towards prevention: the faster reporting and tackling of problems', while the third one states 'an end to non-commitment', which holds that undesirable situations are not allowed to carry on and that both professionals and government have a crucial role to play in child and family policy (Rouvoet 2007). We will show in this article that the last two guidelines, in a context of familisation and despite the ideal of shared parenting, can influence the traditionalising of parental roles. In addition, the policy includes explicitly traditional role pointers such as the 'mama-café' offered in many cities (Thomas 2011; Mama-café 2012).

3.2.2 Normative matrixes around the child's right to care

In the welfare state literature the discourse around balancing work and family in The Netherlands is characterized by shared parenting on the one hand and the labour market perspective with individual accountability on the other. It is therefore striking that the most central themes of medical care dealing with pregnancy and birth can be placed in a very different perspective. The emphasis is on avoiding risk to the child, the importance of expert knowledge, parenthood as open to suggestion and a focus on children and the future (van Teijlingen 2005; Rose & Miller 1992; Parton 1998; Lee, Macvarish & Bristow 2010; Hoffman 2010; Centre for Parenting Culture Studies 2011; van Keulen 2011). The role of professionals in supporting parents when educating children only increases in importance in this perspective (van der Pas 2006; Wubs 2004; Lee, Macvarish & Bristow 2010; Weille 2011; Rose & Miller 1992). Though the situation of parents and children in The Netherlands seen globally over recent years does not show any increase in problems and the position of Dutch children scores high in international comparisons, there has been a large increase in support provision to parents and children (Hermanns 2009; Thomas 2011). In Dutch higher education, parental support as a profession and a methodology is on the rise (Weille 2011; Van der Pas 2006). According to Lee, Macvarish and Bristow (2010) parents are deemed incompetent in adequately assessing risks to their children and therefore professionals, using scientifically based expertise, are

needed to assist them in this. Preventive child healthcare takes a central position in offering care to parents and newborns with respect to both medical care and educational support. The reorganisation and rise of youth and family centres between 2007 and 2011 has reinforced its key position in relation to prenatal care and specialist support.

This demonstrates a distinction between medical care for the child and daycare for children whose parents are working, related to different ideological positions. 'Care' in the welfare literature mostly has the latter in mind, in the form of child minding. (Knijn & Kremer 1997; Leitner 2003). Preventative medical childcare does not easily fit into postwar forms of care organisation according to Knijn and Kremer (1997), in which the welfare state enables (or compels) women to care for their own families while the service state offers professional care outside of the family environment. The dilemma between "the right to provide care" and the "right to receive care" (Knijn and Kremer 1997) is enlightening in this respect. From a welfare state point-of-view, both rights are more or less effectively intertwined in a model of familism or de-familism (Leitner 2003), in which, amongst others, the view of 'best' daycare, being professional or informal, determines the model to be used. In Denmark, for instance, the discourse on the work-care balance sees professional child daycare as being in the interest of the child, while in The Netherlands there has been resistance to this view (Kremer 2007), following a model of familism (Leitner 2003; Christiaens 2008). In the ideological perspective of medical care for pregnancy and birth however, both rights are separate from each other while the child's right to receive care is central and the right of parents to provide care or to be dispensed from doing so (Leitner 2003) is not the focus of attention for medical professional workers. What is most important is rather how parents and professionals can best realise the care of the child. The "right of parents to education support", described by Van der Pas (2006) and picked up by others (Oudhof et al. 2010) is tailored towards the care that children need, helping parents to provide this. While the rights of care providers does not seem to be represented in this context, the notion of "best for the child" does influence the care and division of care of parents. Charles-Edwards (1997), head of the course childcare and children's health at the South Bank University in London, points out that care within the family can lead to an ethical dilemma when the interests of the child conflict with the decisions of the parents. The responsibility of professionals lies with the child in that case. It is therefore important to see how the child's interest is constructed and reproduced.

The normative frameworks that professionals use do not, by definition, overlap with those used by the government. According to Rose and Miller (1992) the upholding of the autonomy of non-political activities in modern societies, in this case that of medical professional workers, always carries with it the potential for resistance by the actors involved. They could take a position against the normative matrix or expert knowledge of governance programmes and/or base themselves on other, competing frameworks. With respect to the role of medical professional workers in their contact with prospective or new parents it means they can exercise their authority within the government guidelines on parenting but equally outside of them. It is therefore important to differentiate which normative frameworks are influential and which images of parents and children are used by government and professionals as 'healthy', 'in the interest of the child', and thus, as 'good parenting'.

Both the pedagogic vision of child healthcare and values with respect to education (Oudhof et al. 2010) and the government policy programme for Child and Family 2007-

2011 (Rouvoet 2007) follow the UN Convention “on the Rights of the Child”. These rights concern non-discrimination, special protection for children to allow development, the right to a name and nationality, the right to social security and healthcare, special care for handicapped children, the right to love, understanding and parental care, the right to education, the right to have help before others, protection against mistreatment, exploitation, child labour and education towards understanding and tolerance, peace and friendship (Oudhof et al. 2010). Hence, child care policy focuses on children and aligns itself in accordance with this on protection, provision and development (Blueband-Langner & Korbin 2007; Oudhof et al. 2010). It reflects the dominant image of children in western societies as vulnerable and dependent (Christensen 2000). Governments and professionals are increasingly aware that parents in all this can be sources of both ‘potential sources of risk’ and protection (Hoffman 2010; Rouvoet 2007). Since the 1980s, the role of psychological insights has become more and more influential in western representations of children. Attachment theory has been a major influence on ideas about safe development of children up to 3 years (Ansell 2005). The importance of safe bonding has often been translated into the necessity for mothers to stay at home in the first years of the child’s life (Juffer 1993). The program for Child and Family translates this to ‘at least one adult’ (Rouvoet 2007).

By implementing the centres for Child and Family in all Dutch municipalities, the government department uses the same language and knowledge as the professionals but also prescribes new rules and forms of organisation, therefore also actively intervening in these activities. This has not led to public protest from the professional sector because child healthcare, in policy vision as much as in programme implementation, invokes the same normative matrix in which the right of the child to care and development is paramount and medical professional workers accompany and support parents in guaranteeing this. The focus on the vulnerable and developing child thus dovetails with the expert attention of government and professionals for the positive and negative influence that parents can have on the development of their children. Parenthood is therewith no longer a private matter (Lee, Macvarish & Bristow 2010), but is presented as a process which, though natural, inevitably provokes questions that everyone wrestles with and which should be (able to be) posed to experts without undue difficulty (Oudhof et al. 2010; Rouvoet 2007; van der Pas 2006; Weille 2011; Hermanns 2009).

Through current government policy the professionals, in line with the ideals of shared parenting and breadwinning, do not focus exclusively on mothers but on parents generally. This gives room for different and changing family units and also invites fathers to participate in caring for children. Given that mothers still work part-time more often and fathers full-time, professionals are bound to see mothers more often than fathers and hence advise the former more often on their responsibilities in providing a good and safe development for their child. In addition, Vuori (2009) has shown that experts in Finland, a country with strong egalitarian opinions, still see motherhood as a duty and fatherhood as an option. In this way professionals can still harbour the ideal of shared parenting alongside a more traditional image of mother and father roles and this can, as Vuori states, lead to the forming and reproducing of gender inequality between parents.

4. The influence of family support workers on the work and care division of parents in The Netherlands

The paediatricians and child nurses in question in our study demonstrate their social role and position between government, on the one hand, and parents and children on the other. Through this the way 'governance at a distance' works, and what its boundaries are, can emerge.

"I think we are only a tiny link in the chain of everything surrounding parent and child and I think we would do well to be quite modest about the part we play. Though government gives us a rather large part. And I, I am not sure. To me that is the problem, we could say that the expectations are too high... For parents arriving here with a question we can play an important role, but for parents who do not have this, I think we are just, well, we are not really all that important" (Paediatrician A).

It appears that this role brings with it, on the one hand, certain expectations from government that any alarm bell is rung promptly and, on the other, that parents only spend a small amount of their time with professionals and are not obliged to follow their advice. Governance in this case is in line with Foucault (2000) and rests on a mix of incentives and coercion, based on the conviction that the expert knowledge of the medical professional workers has to be deployed in order to guarantee the development of the child. The professionals can, in some cases, experience a tension between supporting the parents and ringing alarm bells. The interests and rights of the child would then take precedence.

"If you make them feel that you are with them and really want the best for both child and parents together, then they get this for the most part. But there are certain situations where you really have to stand behind the child because the parents, um, just do not take the time to appreciate what their role should be" (Paediatrician B).

Conversation techniques are essential in explaining to parents why advice is important to the child. This includes giving medical information and explanations around the developmental stages of the child and any future risks. At the same time, it can be necessary to 'intervene', 'persevere' and 'refer to professional care'. This makes clear how governance takes form via the medical sector and how professionals legitimately advise parents in the interests of the child. As will become clear, this is also the framework within which professionals exercise influence on gender-specific parental roles. Parental roles are still differentiated in the daily practice of medical professional workers. Most of the fathers of the children visiting the consulting room work full time, and most mothers

part-time. The professionals have indicated that they regularly receive parents together or just fathers. This is very different from only a few years ago when a father was a rarity. One of the professionals stated that in their centre the father was present in possibly one fifth of the consultations, though with hindsight she thought that might be a little optimistic. In the 34 consultations observed, held over four days, there were 23 mothers on their own, 3 mothers with a female relative or friend, 5 couples made up of a father and mother, and 3 fathers by themselves. In the case of the two home visits, only mothers were present. Although, to our knowledge, the quantitative data regarding percentages of fathers and mothers visiting the consulting centres in The Netherlands is not available, what stands out is that in practice these professionals still mainly seem to deal with mothers, even though fathers are beginning to play a greater role in their experience.

Part-time work is seen by family support workers as the most desirable situation carrying least risk for children. Good practice is spoken of in the case of parents who 'find a balance' between caring for themselves and the child, between career and parenting. They speak positively about parents who work part-time and fathers who are involved in care. When a child nurse is asked among which children and parents in the region least risk is found she answered:

“Yes, just, um, with parents working part-time and, um, a family just getting on with it.” (Child nurse A)

In conjunction with this the professionals talk of the risks associated with two parents working fulltime where a child spends five days in daycare. There is material care there, but perhaps not enough physical and emotional care, more chance of restlessness, less routine, being at several locations per day and more likelihood of tension and child abuse when it is expected that the child has to be 'amenable' in the evenings when everyone is at home tired.

“I have always said that mothers can be, um, I have read this once and thought it true, that you can divide mothers into three categories. The fanatical mum, who is completely obsessed with her child, and um, everything turns round the child and whatever the child wants it gets. Yes, they lose themselves completely in the child...This is really when the child, when the mother behaves like the slave of the child...Then you have, um, the career-oriented mum, who has had a child because, because, just to have a child really. The career is the main thing and the child is an afterthought, and, well, it will grow up anyway. Daycare, or, you know. And then you have something in between. So, um, some balance between career and motherhood, and I think that is healthy. Yes, that is interesting. That is what I read, and, sometimes you see this in people you meet. ...Because that is important, you really have to look after yourself so that you can be a good parent as well. I always say this. If you lose yourself completely in the child, well, I already know, when a parents starts like that they will stagnate somewhere, when the child grows up later.

... And that is also a risk, because when the mother is finished, then the child has no use for the mother either any more. Or the father. And the other one is also a risk because the child is not really getting attention in the right way. Yes, it eats and drinks, and all the material things are there, but where is the child? Where is the feeling, I always think." (Child nurse A)

In the ideal situation therefore there is a balance between career and motherhood. Although the father is mentioned to complete the picture, it is really about the mother. Though the ideal of shared parenting crops up in the language of the professionals it does not mean equally shared parenting. This is also clear from the next extract, about a child with behavioural problems. If there are problems with a child, it is the mother who is first in line of responsibility for care.

"An example of a child of two, I went on a house visit once, and that was really, the child was a nightmare. A dreadful temper and very contrary and... And the mother chose to work for four days. So, the child just had to go to preschool care, and afterschool care. And, um, I said: 'I find this rather a lot'. 'Well', she said, 'I need it because pff'. Ok, so it seemed to be a case of running away from the child a bit. I said: 'I am curious to know how it will go in daycare, because if that doesn't work, the choice will probably be...' I could not steer her of course, I could only discuss. But daycare came out with it: 'I cannot take this child for four days. That is not possible, for her. Three days tops. And to be collected on time, not left till the very end'." (Child nurse B)

This makes clear that the interest of the child is the first departure point and that the primary responsibility for the child's care is laid at the feet of the mother by both the child nurse and the daycare worker. This also makes the term 'running away from' interesting. It seems as if taking responsibility here coincides with a mother working part-time. It is important here to see that a definite tipping point emerges from these interviews, in which four or five days daycare is seen as (too) much for a child. 'Long days', too, could be a reason for worry. In this way a healthy balance is ideally seen to coincide with daycare of three days maximum and/or shorter days. A proportion of children with parents working full time fare well according to professionals, and it is not then their brief to challenge the parent's choice. They do, however, state their impression that they could convey something of their meaning unwittingly and implicitly. This is not seen as good thing. One of them said after a consultation:

"I really think she works long hours, for someone who has two little children. I should not have said it: 'oh, that seems rather a lot'. Some of them might feel guilty, which is not what we are supposed to do, that is not professional." (Child nurse A)

In addition professionals indicate that in many cases, both parents are forced to work because of the mortgage or insufficient means, so that there is no real choice. The professional's opinion is not important in that case. That is not to say it has no influence.

"I cannot understand it when parents have little time for their children, five days of daycare. I can have my own ideas about that, but it makes little difference. There are many households where parents have to work. But I think that here and there it filters through...I do think they feel it in some way". (Child nurse C)

Some parents bring up the lack of choice themselves in consultation and indicate they spend less time with their children than they would wish. Because in this context the word 'she' is used to indicate the parent, this seems again primarily to concern mothers. Some of the professionals indicate that there is a taboo on women who chose to stay at home: these women supposedly do 'nothing'. According to the professionals, this needs to be reevaluated. This demonstrates that they experience not only a financial, but also a social pressure to work. Furthermore it reflects the ideal of choice in work and care duties. The staying at home full time of mothers is not portrayed as an ideal, since it carries the risk of a mother getting stuck and no longer being there for the child and of a father who is not involved in care. The professionals do not talk about any pressure parents might feel to stay at home or about parents who say they wish to work more. Within the matrix of freedom of choice, this does not seem to come up in the contact between parents and family support workers.

When doing home visits after birth child nurses bring a questionnaire asking for the number of hours worked by mother and father and the type of daycare that will be used. This information gets fed into the digital file which is read during a consultation. The mothers were asked by the child nurse during the observed house visits: "do you work part-time?", followed by "and the father full time?" These leading questions carry the assumption of the one-and-a-half-earners-model. Part-time work thus seems to occupy an ideological and factual middle ground, between the two extremes of a non-working mother and one working full time, in which the ideal of choice is optimal. This seems, in turn, to imply a choice for both fathers and mothers but it is also clear at the same time that the primary responsibility remains with mothers.

When signals of anxiety or problems are flagged up for children or parents, the work situation is one of the things most often brought into discussion to see whether there are possibilities for altering it. Fathers are reminded of their leave options or bring it up themselves. They complain specifically about the very short leave of two days. The professionals indicate that they are in favour of giving fathers more paternity leave and note that in many work places there is still little room for part-time work for fathers. From the interviews it transpires that they sometimes advise parents to work fewer hours. This could be because the child's circumstances demand it, but also because the combination of work and care is a heavy burden. When asked, they indicated doing this only with mothers and not fathers.

Interviewer. "Do you still advise on that, number of hours worked?"
Paediatrician B: "No. Only if I see that, um, for example, a mother working four days and who is struggling, um, has a hard time, then I would discuss it. Something like 'Have you considered working less, like parental leave is an option, or just putting in fewer hours maybe?' Or, yes. The choice is always for the parents themselves whether it is financially possible, but um, if I see that parents get stuck, or the mother, then I will certainly discuss it. The option, whether it isn't a possibility. Interviewer: "and do you also advise father sometimes to work less?" Pediatrician B: "Not really. No, never. (Laughs.) No."

The professionals think this is because mothers are more preoccupied with finding the work-family balance and because they assume that fathers cannot reduce their workload because of social or financial pressures. All the professionals mention a low profile in relation to the work of the parents. At the same time talking the work setup through does suit some professionals in some cases, while others content themselves with 'commiserating' the short leave periods for fathers.

To summarise, our empirical material supports the conclusion that family support workers encourage, wittingly and unwittingly, certain gender-specific ideals for care in their daily contact with (new) parents. In this they see work and care duties for fathers as well as mothers, and as such they demonstrate clearly egalitarian values with respect to gender and value choice for both parents. At the same time, professionals transmit to parents the idea that a home setup with parents working part-time is in the best interest of the child and entails the least risk. Shared parenting does not mean that both parents need to perform comparable tasks. In practice professionals only discuss the idea of working less with mothers. By being aware of financial restrictions or restrictions in the work atmosphere of fathers around part-time work or taking parental leave and because the normative starting point remains the healthy development and wellbeing of the child, primary responsibility for the care of the child stays with the mother. In the interests of the child they need to find a right balance between work and family. In this, the most important thing for a child is held to be a 'safe and comfortable nest'. Because mothers go to medical professional workers more often than fathers, it is mothers who are reminded of their responsibility more often than fathers and who are also more susceptible to it in a context of familisation.

5. Discussion and conclusion

European countries increasingly focus their family policies on the combination of work and care. The recent shift towards shared breadwinning by young parents means a break with the cultural ideal of stay-at-home mothers and familialism that had been dominant in European family policy in the twentieth century. The norm of shared breadwinning also conflicts -varying in degree according to country - with the existing shortcomings in care provision for children under three. In this situation new parents have to make choices in the division of work and care.

This article shows that a family policy using a model of choice in a context of gender neutrality does not per definition lead to a decline of gender-specific parental roles of fathers and mothers. Despite the fact that both fathers and mothers formally have access to part-time work, leave and daycare for children, traditional role patterns persist. In The Netherlands a discrepancy within government policy plays a role. Women are encouraged to participate in the labour market but this still happens in a context of familisation. The shortage of care provision for the first years of a child's life implicitly lays it at the feet of the mother. Parental behaviour can also be understood in relation to the institutions they have to work with. We conclude that preventive medical childcare has relevance to the division of care for parents. This care does not fit easily into the postwar forms of organisation of care in The Netherlands. On the one hand, the welfare state allows (or compels) women to care for their children financially. On the other hand, family professionals suggest that the mother is an important caregiver for small children and that a mother's full time work constitutes a potential risk to the child's development. Expert medical knowledge regarding children increasingly focuses on the secure development of the child, to which the right of the caregiver to care or be dispensed from caring is subordinated. Family experts echo government policy based on the rights of the child and governments can modulate parental behavior at a distance this way. It is therefore legitimate to ask whether 'shared parenting' in government policy means gender-neutral and comparable parenting and which priority is given to it.

At the same time the medical sector has its own set of rules based on preventing and addressing risks in which its professionals operate. In their professional sphere, and with subjects where clear guidelines are lacking, they can choose to use stereotypical images of gender-specific parenting and/or fall back on medical expertise aimed at the interests of the child. We have shown that both strategies can be found among pediatricians and child nurses in the childcare system. Despite values of equality and esteem for the involvement of fathers, the ideal of part-time work and the tipping point of four to five days daycare have consequences for how professionals approach mothers and fathers. In practice it is mothers who remain primarily responsible for guaranteeing the child's interests and finding a work-life balance. This can explain why there is a gap between notions of equality on the one hand, and gender-specific care patterns in practice on the other.

The evidence we have found is limited, in the sense that our study only focused on The Netherlands and only concerned a first cautious analysis of ongoing research within the professional sector. These reservations notwithstanding, we can already learn from this approach that studying the gender-specific behaviour patterns of parents in relation to institutions, such as government policy and the professional sector, increases our understanding of persistent traditional role divisions and gender inequality. The

implications of this for comparative cross-national research is that one can analyse whether the coupling or uncoupling of government policy and medical institutions influence gender patterns differently. The concept of 'governance at a distance' (Rose & Miller 1992) can, in this way, be applied to other European countries because it is not so much the mechanism that differs as the type of regime or the normative matrixes in play. Moreover, and this is where we go further than previous research in this field (Murphy 2007), we have shown that governance via medical expertise goes much further than the domains of breastfeeding and raising children. It touches on the gender-specific division between paid and unpaid work and thus influences the social structures of gender inequality.

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