Who cares? An ethnographic research on the workforce integration of first-generation immigrants in geriatric care in the Netherlands and Germany

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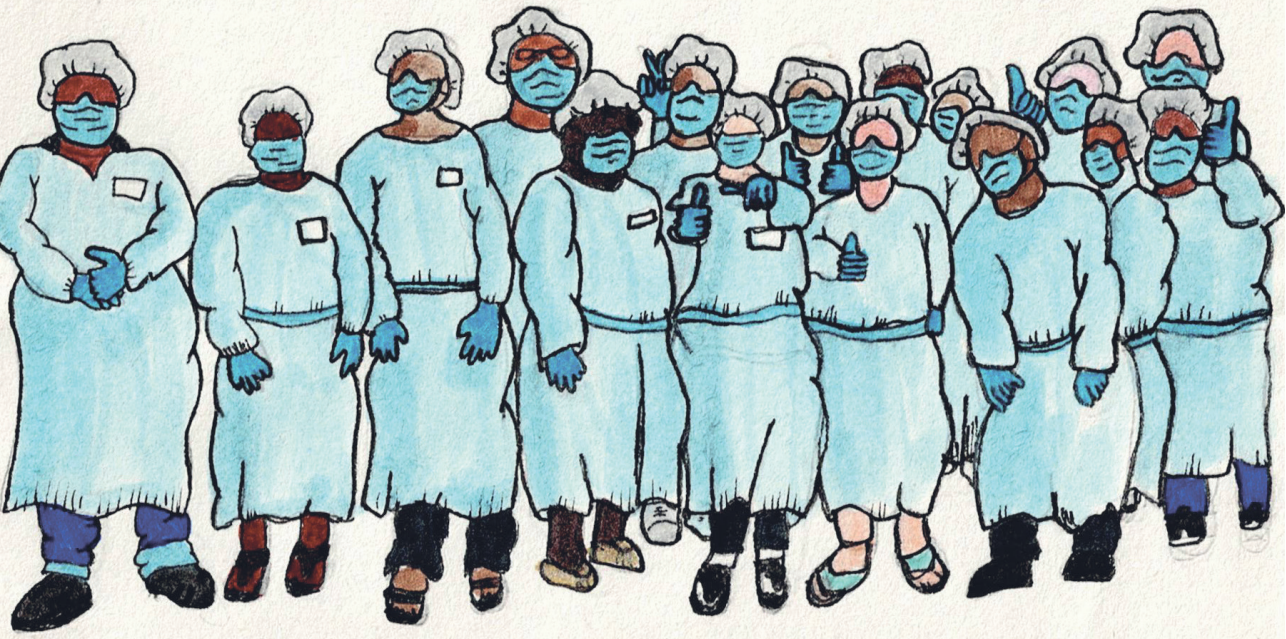

Chapter 6

THE WORKFORCE INTEGRATION OF FIRST GENERATION IMMIGRANTS IN GERIATRIC CARE IN THE NETHERLANDS AND GERMANY

General Discussion and Final Conclusion

The workforce integration of first-generation immigrants in geriatric care in the Netherlands and Germany

INTRODUCTION

The research presented in this thesis is conducted in a field of demographic changes in ageing societies in Western Europe, resp. in the Netherlands and Germany. Due to the so-called refugee crisis in 2015 and 2016, many immigrants from countries such as Syria, Eritrea, Iraq and Afghanistan settled in the Netherlands and Germany. Among them there were qualified nurses and people who were willing to work in the care sector.

A Dutch and a German residential home were very willing to open their doors for those new care workers. The Dutch residential home recruited ten newly arrived immigrants with a refugee background, mostly with a nursing background, and provided them with a retraining and work in the nursing sector, together with Dutch language lessons. This training, including internships, lasted 18 months. The German residential home provided first generation immigrants with a refugee background a three months orientation course in nursing care, i.e., two months of education and one month of internships in the wards. After this course, they had the opportunity to follow an official nursing training to become a certified nurse assistant.

Studies have shown that when immigrant care workers start at the work place in their host country, they experience multiple problems, such as cultural differences, language difficulties and miscommunication. The established staff do not always know how to deal with these problems. They often disqualify the complaints of their new colleagues, while denouncing their different way of working as unprofessional (Van den Broek, 2014).

Until now, most research into the ‘integration’ of immigrant careworkers was based on interviews, and as a consequence focused primarily on the feelings and interpretations of the established and immigrant staff of their work experiences. Little attention was paid to the context and conditions they worked in, or to what actually took place in the events they reported about.

Workforce integration and problems that arise with the arrival of newcomers are well known from previous research (Schaafsma, 2008; Ulusoy, et al., 2020; Wessendorf, 2019). Institutional factors affecting the integration of newcomers into

the nursing workforce were also a strong theme in the cross-sectional survey by Covell, et al., (2021) and in the qualitative research studies by Philip, et al.,(2019), Xiao,et al., (2014) and Zhou (2014). Other researchers focused on how organizations are dealing with diversity (Thomas and Ely, 1996) and there are scholars who studied the lack of job opportunities of immigrants, their inequalities and their position in Dutch and German societies (Ghorashi and Rast, 2018; Khan-Gökkaya and Mösko, 2021; Ulusoy and Schablon, 2020).

Most studies on workforce integration studies provide knowledge about the perspectives of established health care workers or first-generation immigrants, about the factors that in their view affect the workforce integration, the multiple challenges they face in dealing with the Other, their cultural differences, the individual and structural barriers, such as language difficulties and intercultural communication and conflict resolution (Kingma, 2018; Spijkerman, Benschop and Bucker, 2018). There are also studies which focus on the potential of refugees and asylumseekers for care work. Those studies, also based on interviews, highlight the difficulties of workforce integration into the health care sector, due to difficult work conditions (Hussein, et al., 2011). Xiao, et al., (2014) provide in their study information about factors that foster positive interaction between immigrants and native workers, such as organizing meetings for intercultural understanding and providing egalitarian work relationships (Xiao, et al, 2014). However, the above studies are based on interviews or focusgroups and are done in countries such as England or Australia.

There are also studies conducted in the Netherlands and Germany which explain barriers regarding workforce integration of first-generation immigrants with a refugee background (ACVZ, 2021a; Horn, Schweppe, Böcker & Bruquetas-Callejo, 2021). The results explain why immigrants face difficulties in these countries at their working career. Different reasons are mentioned, such as language difficulties, no qualifications, age upon arrival in the host country and/or mental health problems due to war traumas (Bakker, et al, 2016; Horn, Schweppe, Bocker and Bruquetas-Callejo, 2021). Moreover, first-generation immigrants with a nursing background from outside Europe face difficulties to access the labour market in the Netherlands and Germany, because their foreign diploma's are not recognized in their host country (ACVZ, 2021b; Böcker, 2020). Other studies in the Netherlands and Germany reported interview results about the experienced racism and discrimination at the health care workplace (Cottingham and Andringa, 2020; Essed and Trienekens, 2008; Ulusoy and Schablon, 2020).

This study, based on ethnographic methods, followed first-generation immigrants when they started a (re)training program in residential homes and during their internships in the wards. This research was primarily based on participant observation in the retraining programs and in the enactment of care as it took place in daily practice in the homes. From the start of this research, I took the outsider-perspective of immigrant workers seriously, assuming that it might provide interesting critical insights in the pros and cons of the taken for granted routines and habits in the Dutch and German health care sector. Moreover, the findings from such a 'reversed gaze', it was expected, would stimulate established health care workers to reflect upon the values and assumptions underlying their own practices of care, and make them open to and flexible toward 'different' enactments of care.

The Dutch residential home had no experience with diversity management. When a new group of employees from outside Europe entered the home, the management adopted a trial and error approach. If they encountered a problem along the way, they tried to solve it at that moment in that particular situation, for example by transferring a newcomer to another ward, when colleagues complained about the competence of their new colleague. The management in the residential home in Germany, in contrast, foresaw the collaboration struggles between new and 'old' staff. Their remedy to prevent misunderstandings between established staff and newcomers was to provide specific trainings to all involved. The course 'Care for the Elderly' was given to the newcomers with the aim to provide them with not only basic knowledge and skills to be able to provide psychogeriatric care, but also strategies on how to collaborate with the established colleagues. The course 'Care in a Cultural Context' was given to the established staff members, with the aim to respond adequately to their new colleagues, with less prejudice and an open mind.

Management who initiated the newcomers' projects in both residential homes envisioned a collaboration between established staff and newcomers, where there was mutual understanding and exchange, reciprocal learning and appropriate teamwork. These were good intentions on the part of the management, but their expectations were sometimes in contrast with the daily reality in the departments. In both residential homes, organizational constraints, such as shortage of staff, increasing absenteeism and a heavy workload dominated and affected the *ability* to create room for each other, as there was often no time for mutual exchange and reflection.

This research focused on the enactment of care, more in particular, it investigated geriatric care as the outcome of a process of mutual alignment, or tinkering, of the different routines and conceptions of good nursing care by established and immigrant health care workers in two residential homes.

The aim of this thesis was to develop an in-depth understanding of social processes in institutions for geriatric care where first-generation immigrant workers and established staff members start working together, and to investigate how their interactions and values of care influenced the enactment of care. In this chapter the main empirical findings are revisited to answer the following central question:

> *How do social processes and values of care affect the interactions between first-generation immigrants and established health care workers and how do these dynamics influence the enactment of good care?*

I took a Dutch residential home and a German residential home as case studies. In the first section, I will address the first sub question: 'what are the social processes affecting the workforce integration of first-generation immigrant health care workers in a residential home in a Dutch and German residential home?' In the second section, I will address the second sub-question: 'how are values of care enacted by established health care workers and first-generation immigrants in a Dutch and German residential home?' I will then draw the main conclusions. After having discussed the strengths and weaknesses of this study, I end by outlining some implications for practice and future paths of research.

EMPIRICAL FINDINGS

Social processes in a Dutch and German residential home

The Dutch and German residential home studied here provided care to psycho-geriatric residents, some of whom suffered from dementia. In the Dutch home, the older residents were cared for by native health care workers. Most employees were born in the village, as such they formed a close-knit *Gemeinschaft,* with a high degree of internal cohesion, especially through church memberships and family ties (Tönnies, 2012, p. 29).

The German residential home was more seriously affected by the shortage of caring staff. Since 2003, they had recruited caregivers from within and outside Europe, from countries such as Poland, Yugoslavia, Bulgaria, Russia, Turkey, South

Korea, Tunisia and the Philippines. Thus, the residents in the German residential home, were cared for by a more diverse team whose members came from widely varying communities. Both institutions were facing shortage of staff.

Due to the high influx of refugees in both countries and a shortage of staff, each of the two homes initiated a project for first-generation immigrants with a refugee background to start a nursing career. Some of the immigrants had gained a nursing diploma in their country of origin, others were interested in an orientation in nursing care practices. In both homes, the established staff were challenged by these new personnel with a different cultural and educational background. Management had given the established staff an extra task, on top of providing care to the geriatric residents, they were assigned to take care of their new co-workers. In both the Dutch and the German residential home it appeared that processes and structures at the meso-level of the organizations affected the social interactions between established employees and first-generation immigrant workers. Therefore, social processes between people cannot be studied in isolation, they are shaped by the context in which people find themselves, such as institutional structures and organizational constraints.

Institutional structures and organizational constraints

Since the 1990s, both residential homes had been affected by the commercialization, reorganization and privatization of health care practices. This caused years of austerity and in both residential homes scarcity predominated. The homes suffered from a structural shortage of staff and at the same time the influx of older residents with multi-morbidity increased. All health care workers had to deal with a heavy workload. This caused a lack of attention to the older residents in both homes, who did not receive the person-centered care both institutions were aiming for. Care workers worked hard, but the work piled up and was never finished.

In order to solve the above problems, both homes had recruited more (low-skilled) staff in the past. For control and financial reasons, the Dutch residential home had introduced a specific duty list, where each task was divided into minutes. For the health care workers this institutional measure caused a lot of stress and required an even more disciplinary way of working. Combined with the chronic shortage of staff, this resulted in a persistent workload with hectic work schedules. In Germany, other factors also influenced care practices. For example, at the time of this study,

on top of the heavy workload, the staff had to deal with an aggravated outbreak of scabies and with an extreme heatwave while providing care in a poorly ventilated building. This combination of factors put pressure on the care workers and they were not always able to work according to professional standards. They were only able to attend to the basic needs of the residents, such as helping them with washing, dressing and eating.

Norms of professionalism

In both homes there appeared to be a big difference between the self-image of the established team and their image of the other group, the newcomers. Some of the employees in the Dutch home had stereotypical images of primitive cultures and thought that their new colleagues came straight from the bush. Workers with African roots, so they believed, were not able to work according to European 'high-tech' standards. They doubted the professional capacities of the newcomers and complained about their different behavior. They questioned whether the new staff was capable to care for older residents. For example, one of them doubted if a newcomer was adept at inserting a catheter, another was convinced that she was unable to work according to their standards of hygiene. In the German home, the established staff doubted whether men from outside Europe were capable of providing good care, because care was considered a woman's task in non-Western cultures.

The data showed that some of the established workers believed themselves to be the better care providers. Some claimed that their norms of professionalism were better than those of their counterparts. The arrival of newcomers was experienced as a threat to their well-functioning team and their normal way of working. They refused to cooperate with them and approached them as low-skilled people. They treated their new colleagues as people who did not belong in the caring team of a home for the older people, in other words, they treated them as outsiders.

In the Dutch home, the established workers claimed that caring professionals should be motivated, interested, and extrovert. In addition, they should be assertive and take initiative. In the German home similar norms of professionalism were voiced. The established team members said that the newcomers should be motivated, able to see the work and be interested in geriatric care. A caregiver must care from 'the heart' and needs to have the right skills.

In both homes, several established care workers were observed to pay little attention to their new colleagues, some even simply ignoring them, acting as if they were not there. They felt themselves to be better workers, due to their years of experiences and their shared norms of professionalism.

In the Dutch residential home, most established workers were born and raised in the village where the residential home was located. In the German residential home the established group existed of native Germans and of people with a migrant background. Some empathized with the situation of the newcomers, due to their own integration experiences. Still, they too felt that they were better workers than the new arrivals, they were reasonably well integrated in the group of native care workers. They had worked for years in the residential home, had developed a common habitus with the native German workers and were familiar with the formal rules and procedures. For these reasons, they considered themselves better workers.

Nevertheless, in both homes a few newcomers were perceived by the established personnel as hard working, responsible and altruistic workers, as positively engaged in the well-being of the residents.

Some of the newcomers, on the other hand, were also critical of the professionalism of the established staff. For example, the newcomers in the Dutch home were critical of the lack of hygiene. In their view, the lack of protective equipment involved a risk of contaminating the residents. In the German home, the newcomers felt that they had a better attitude, had more respect for the older people and were more patient with the residents compared to the established staff.

In both homes, some immigrant workers were suspicious of the way their new colleagues treated them. Some for instance suspected that their to-do list was always longer than the list of their established colleagues. Or they assumed that they always had to do the ‘dirty’ work, such as cleaning up human excrement.

All the newcomers agreed that nursing in Europe is ‘individual-oriented’ compared to the ‘team spirit’ they knew from the experiences in their home country. They also found that, compared to what they were used to, the focus of nursing care in the Netherlands and Germany was not so much on the medical, but on the social aspects of care.

Power of the weak

The empirical data showed that the social dynamics within the nursing teams in both homes was based on a particular configuration, i.e. a web of interdependence relationships between established and newcomers. The core of such a figuration, as Elias and Scotson have argued, is an unequal balance of power between the two groups and the inherent tensions that come with that. Conflicts in both homes were related to these differences in power. They often involved a power struggle by the established care workers to maintain control and their position of authority.

In both homes, the established staff were in charge of the department. They tried to confirm their stereotypical images of the 'others' by making a sharp division between themselves, the established group, and the new group of workers.

Members of the established group, as mentioned before, distinguished themselves in a positive way from the others by referring to their length of residence, their work experience in the homes and their presumed professionalism. In both homes, various institutional obstacles affirmed and reinforced group divisions and collective images of 'us versus them'.

The newcomers on the other hand, also tried to maintain control over their situation. In the German residential home, for instance, some newcomers refused to provide care to the older residents for several reasons. During the training in classroom, they were told not to do tasks that were outside their comfort zone. In practice however, they found that the established staff sometimes assigned them tasks that presented them, the newcomers, with dilemmas. For example, in one case it was unclear to a newcomer who would be held responsible if the resident fell, so he refused to shower a resident in a slippery bathroom. Another newcomer refused to clean a resident who was covered in excrement, because the smell made him nauseous. His technical training in engineering proved to not make him the most suitable candidate for a nursing career in Germany.

The empirical data in both homes showed that the established staff placed the work of their new colleagues under a magnifying glass. During breaks, they gossiped about their unprofessional behavior. In the Dutch home this once even resulted in a newcomer being relocated to another department. The newcomers were perceived as the 'bad apples' in their team.

Although the established staff members had more power than the newcomers, they felt powerless against the management. The staff felt that they, the people who actually had to work with the new workers, were not involved in the management's project. They were convinced that the management had no respect and no insight in their daily situation. Through gossip the established care workers sought to protect and affirm their professional attitude, beliefs and norms, while it also served as a means to reinforce the position of the newcomers as 'outsiders'. Gossip strengthened the internal team cohesion of the established care workers. In this respect, it was an 'effective' form of resistance, functioning as 'a weapon of the weak' to control their situation and maintain their professional identity. In line with the established and outsiders' theory of Elias and Scotson, it instilled a sense of power and superiority among the established staff.

However, the gossip by established workers adversely affected their relationship with the newcomers, who were well aware and critical of it. They condemned the way mistakes were handled. They felt that mistakes should be discussed privately rather than gossiping about them with everyone. They were convinced that the established staff should work according to the etiquette of the ward.

When I was in class with the newcomers in the German home, I noticed how the newcomers also gossiped about their colleagues. During breaks, they for example spoke with each other about the disrespectful behavior of the established staff and were critical of how quickly the morning wash had to be done. Some newcomers talked about how the established colleagues served food impatiently and did not wait for the older people to finish their food. For them, gossip was a form of resistance as well.

Resentment and pain of indifference

In the Dutch home, the established health care workers felt resentment because the management seemed to favor the new co-workers, for instance because the newcomers were offered educational opportunities that they were deprived of. They viewed themselves as the good people who were motivated and worked hard, but were sidelined and not appreciated by management.

In the German home, the established workers resented that the management had not asked them for advice on this project. They all agreed they needed more personnel, but not these inexperienced workers. Some established workers were

angry for the extra coaching task they were given, whilst they did not have time for the intensive mentoring the newcomers needed. One nursing student with German roots felt frustrated that she had been forced to share supervisory time with the newcomers. Moreover, the established workers with a migrant background and without a health care diploma were especially afraid that the new arrivals would 'steal' their jobs.

The newcomers in both homes also felt resentment. They felt disrespected by both their established colleagues and the management. The newcomers in the Dutch home for instance blamed management for not taking charge when a resident refused the care of one of them. The newcomers in the German residential home felt that they were expected to do tasks outside their comfort zone. The newcomers in both homes were critical of the management for failing to recognize their preceding education, knowledge and skills. Their previous work experiences seemed not to matter at all. Some newcomers were convinced that they were not given equal opportunities to secure desirable employment, even though they realized that they needed to improve their language. They realized they were in a catch-22: they needed work experience to improve their language skills, but to gain work experience, they needed better language skills.

All newcomers missed collegial support. They wondered why there was no structural mutual exchange between the newcomers and the established colleagues. Moreover, all newcomers were convinced that if their colleagues would accept them, so would the residents. According to the newcomers, management was responsible for facilitating good working conditions. In both homes, the newcomers blamed management for not taken the lead.

In sum, the established and newcomers in both residential homes suffered from feelings of neglect and pain of indifference by management. Both considered the 'elite' and the 'other' as the main source of their pain and discomfort.

Language difficulties

Apart from the language lessons in the residential homes, in both countries the immigrant health care workers also participated in the compulsory national integration courses and language training. However, some participants got frustrated when they failed several times for the state exam for integration and language. They had to pass this exam, in order to be eligible for a permanent

resident permit. This was the major reason for newcomers to learn the language, but they also realized they needed language skills to be able to provide good care. In both residential homes, newcomers' struggles with communication caused problems in their interactions with their colleagues and with the residents. Even though they tried hard to learn the new language, it was difficult to understand the nuances in the nursing jargon and the local slang of established colleagues.

In both homes, the process of segregation was not only due to the established-outsider figuration, but also due to these language barriers. This was especially noticeable during the breaks. The established group and the newcomers sat at separate tables in the canteen. The established employees and the newcomers chatted among their peers, but not with each other. During interviews, the established staff in the Dutch home indicated that they noticed that the newcomers were sitting at different tables. While some employees wondered why their new colleagues were so quiet, others assumed they probably were not interested in their stories. After all, they talked about events the newcomers had not attended, told stories about the past or about people in the village. One established worker was convinced that the local language was too difficult and the slang too hard to follow, believing that by not speaking to them during breaks she relieved them of having to make an effort to talk to their Dutch co-workers.

On the other hand, in both homes the newcomers wondered why the established staff did not talk to them during break. But they did not dare to ask. Some newcomers were shy, others thought that the native staff did not want to talk with them, because their language was not good enough. One newcomer suspected that the native employees had a lack of interest in her. She even reported this to management. When her report was not followed up, her suspicion was confirmed that none of them, including the management, were interested in her.

Although the newcomers tried to identify as well as they could with their new role and position as health care workers in a different caring culture, their difficulty with the language and their unfamiliarity with other professional norms of nursing caused insecurity. They had to find out for themselves how to shape their professional identity as a health care worker again. However, sometimes they became frustrated, for example, when in the German home the established workers spoke Polish, which hindered them from improving their German language skills. Some newcomers found the language such a huge barrier that they wondered if

they would ever master the language well enough to work in a residential home or in a hospital, the place where some had gained their experiences in their home countries. Most newcomers however, realized that they needed to develop a feeling for nursing care in their new country, i.e., they needed to acquire a new habitus, based on an in-depth understanding of how things worked in this new work environment.

ENACTING BODIES AND ENACTING VALUES IN DAILY PRACTICE

This paragraph addresses the tinkering between the established and newcomers and between different values by answering the second sub-question:

'how are values of (good) care enacted by established health care workers and first-generation immigrants in a Dutch and German residential home?'

In the Dutch residential home, buddies of the established staff and newcomers were actually working together. This gave me the opportunity to observe the ways in which they managed to tinker between each other in order to enact good care to the older residents. In the German residential home, however, due to the severe shortage of staff, the newcomers had to work on their own. In the German home, I analyzed whether and how established staff and newcomers were able to tinker between different values in their enactment of daily care practices.

Tinkering between established workers and newcomers

In the Dutch residential home, some established staff members had signed up as a buddy to support their new colleagues. These buddies enjoyed supervising the newcomers and created a bond with them. Some established workers indicated that they had learned new professional skills from their new colleagues. They valued their professionalism and asked questions about customs and habits in nursing care in their countries, without immediate negative judgment. And opportunities for situational acting arose. Sometimes the established staff member made room for a newcomer to take initiative and be creative. Despite the language difficulties, the established staff and newcomers were able to care together, creating a safe atmosphere for residents, sometimes sharing in fun and laughter. Although both had to keep track of their duties and felt pressured to meet institutional standards, buddy and newcomer exchanged ideas and thoughts. In some situations, the

power relation even temporarily shifted. For example, when a female buddy and a male newcomer took care of a male resident, male bonding predominated.

The established staff reported that to give the new colleagues the necessary support, they felt they needed more space and time, time that was not on the minute lists. The newcomers on the other hand, were impressed by how efficiently care was organized in the Dutch home. They for instance found the precise minute list very useful for knowing the tasks that needed to be done. However, they also commented on the disadvantages of this highly individualized and controlled way of working: they wondered whether, if needed, the staff would be willing to go the extra mile. With other words, would the staff be willing to do some extra tasks for their residents if this was not written on the (precise) minute list?

Not every situational solution, however, could be perceived as an example of tinkering in order to provide good care. In one case, when a resident refused the care from a newcomer of color, the practical solution among buddy and newcomer was that they swapped lists. At first sight this seemed a good example of tinkering because all residents received proper care. On closer inspection, the negative side was that the newcomer was denied support when faced with the problem of racism.

Tinkering between different values

In the German home, established staff members were not asked if they wanted to coach the new employees. On the duty list, the manager had simply randomly assigned newcomers between an established care provider and the newcomer, thus assuming that the coaching was covered. However, in practice, this turned out differently. The severe shortage of staff, the huge workload, the accountability and registration requirements led to a lack of time to support the newcomers. To manage all their tasks, the established staff divided the tasks at the start of each shift. They left the newcomers to care for the residents on their own, without anyone checking whether they were working according to the required standards. Some staff members showed the newcomer the routines in the ward on the first day, expecting them to know on the second day. Others were not at all willing to work with their new colleagues. They did not even bother to show them the routines, but just handed them the list with the rooms of the residents they had to take care of.

Due to the fact that established staff and newcomers were not working together, in the study of this home I analyzed how the health care workers, whether they belonged to the established staff or were newcomers, tinkered with different values of good care.

During interviews, the established caregivers said they adhered to the institutional rules regarding public accountability and at the same time were able to provide person-centered care. Although the newcomers likewise tried to live up to the institutional standards, they were sometimes observed to make different choices. For example, while an established worker took care of the nursing reports, thereby complying with the institutional values of accountability of care, the newcomer initiated to play a game of 'Mensch ärgere dich nicht!' with some of the older male residents, thereby adhering to the value of person-centered care. In this case seemingly conflicting values worked 'smoothly' side by side.

But sometimes care providers faced dilemmas where they had to choose between conflicting values, for example between the values of autonomy and hygiene. In such situations they could not apply institutional rules, but had to make their own decisions, which were determined by the specific circumstances of that situation. It meant that living up to the value of autonomy for the resident went at the expense of the value of hygiene.

Often, there was no problem with living up to the values of efficiency and carefulness simultaneously. For instance, it was quite possible to give medicines in a few minutes, while respecting the quality of care, for instance by the value of paying personal attention to the residents. However, sometimes efficiency came at the expense of carefulness. One of the newcomers was known for working efficiently within the set time. The established staff had complimented him for his fast pace. However, because they did not actually work together, his colleagues did not see what the newcomer was doing when he provided care. When I shadowed him during his care work, it was seen how he indeed managed to help an older lady getting washed and dressed within the allotted time, but that, (in the eyes of the beholder), the quality of care left a lot to be desired.

This study shows that tinkering with values always takes place within a certain context and is based on a normativity related to the concrete situation in which values are pursued or are imposed in practice. Every interpretation of a situation involves a normative evaluation. For example, in some situations care providers may simply seem to tinker. At first glance, this for instance happened when employees did not intervene when, in full view of the other residents, an older woman undressed, sank to the floor naked, screaming uncontrollably. As the care workers explained afterwards, this was their best solution, because experience

had taught them that leaving her alone in her room would mean she would cover herself with feces. In other words, they seemed to be faced with a so-called, tragic dilemma where they had to choose between two evils, in this case to violate either the dignity of the woman, or the tranquility of the other residents. Whatever their choice, the outcome would be negative.

However, if we zoom out and look at the broader context, it becomes clear that the institutional and organizational conditions of the residential home should also be taken into account. Work that piles up and is never finished, is not only hard work, it is also exhausting. Healthcare workers who are structurally unable to meet their professional values due to lack of time, run the risk to become indifferent and behave thoughtlessly toward their clients. This is what we sometimes observed in the residential homes: not only did the staff stop paying attention to their own (professional) values of good care, they sometimes no longer even realized that boundaries were being crossed, amounting to an outright neglect of residents entrusted to their care. Neglect due to force majeure because they had to be everywhere and nowhere at the same time. What the above makes clear is that analyzing care situations, the context cannot be dismissed. If in the above situation the team had not consisted of three but of, for instance, five health care workers, they could have come up with other ways to deal with this precarious situation, such as one of them putting a warm blanket around the distressed lady, and staying with her till she calmed down. The latter situation could then be analyzed as care providers who tinkered and provided care with attention to the craftmanship of their profession. However, established health care workers and newcomers who find themselves in a complex and demanding environment, requiring an unlimited demand for responsiveness, can become exhausted. People may then no longer be able to weigh up different values, but become absorbed in the demanding environment, can become demotivated and indifferent to the point that they are numbed, act thoughtlessly and thereby harm their clients. Institutional constraints can therefore influence the interactions between established health care workers and newcomers and their ability to enact good care for their residents.

In the Netherlands and in Germany, some of the newcomers did not want to continue with the caring work, despite the fact that the newcomers saw the residential homes' project as an opportunity for a new start. They felt stress due to the huge responsibilities, the irregular shifts and the low salaries. Some already quitted within a few months, unable to combine the stressful job with the nursing training, or

caring for their children, others continued with different education after the project; only a few immigrants saw career opportunities in the geriatric care sector.

COMMODIFICATION IN RESIDENTIAL HOMES

This research was conducted in two residential homes, in two countries. This is a rather limited sample, from which no straightforward generalizations to other health care institutions or other countries can be made. However, through extensive fieldwork (305 hours), four focusgroups with a total of 26 participants and in-depth interviews with 32 respondents, in-depth information was obtained about the social dynamics and everyday interactions between established workers and newcomers in residential homes and the impact of the broader economic and societal context on these relations at the workplace.

Although most studies on the integration of first generation immigrants in European health care focus on the supposed cultural differences and/or deficiencies of newcomers, the present study not only focused on the experiences or perspectives of established care providers and newcomers, but also analyzed what actually happens at the workforce, and how careworkers interact in everyday practice.

In this paragraph I will return to the central research question:

How do social processes and values of care affect the interactions between first-generation immigrants and established health care workers and how do these dynamics influence the enactment of good care?

This study has shown that in order to understand the social processes between established care workers, immigrant newcomers and older residents in a residential home, it is important to take the broader institutional and societal context into account.

When newcomers from outside Europe integrate into European care institutions, difficulties that arise are often explained by cultural or ethnic differences. This study however shows how quite different mechanisms play a role. It shows how scarcity (i.e. of time, personnel and resources) has a negative impact on the dynamics between insiders and outsiders, and how such tensions make it more difficult for them to tinker amongst them or to tinker with conflicting values of care. These mechanisms influence the daily care in a way that everyone involved regrets, because they further deteriorate the care for the older residents.

Market-driven values and the value of care work

Health care institutions, such as residential homes, want to improve the quality of life for their older residents. The quality of life is defined by the World Health Organization as: 'An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad range concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships and their relationships to salient features of their environment' (WHO, 2010).

Dutch and German health care institutions are doing well internationally concerning life expectancy, preventable deaths from treatable diseases and perceived health (OECD, 2021). Still, the Netherlands Scientific Board for Government Policy (WRR, 2021) has argued that government has to make better choices about where their priorities lie in the health care sector. The WRR acknowledges that there is a structural loss of quality care in Dutch residential homes. This loss of quality is also noticed in German residential homes (Eggert, Schnapp and Sulmann (2017). In 2007, for example, the medical service of the health insurance companies [*Medizinischen Dienstes der Krankenkassen*] reported, older residents in care homes do not receive the care they needed; one in three residents in care homes does not get enough to eat and drink, they have bedsores and people with dementia are seriously neglected (Germany Institute, 2022). The caring staff in this study also indicated that they are dissatisfied with the quality of care they are able to offer. According to them this leads to a decrease in the quality of life for the older residents.

Since the 1980s, due to growing concerns about the costs of the welfare state, the ideology of neoliberalism has gradually become dominant in western societies. This led to a declining role of national governments, and more room for private initiative. It was believed that the best and most cost-efficient way to provide public goods would benefit from regulation by the mechanism of the free market. Hence, formerly collective goods such as education, housing or public transport became commodified, i.e. changed from something of human or social value into an object of trade, a thing that can be bought and sold on the market. As the sector of health care was also faced with ever higher costs, leading for instance to long waiting lists, these principles were also introduced here, be it that the market of health care remains to be heavily regulated by law (Helderman, et al 2005; Tonkens, et al, 2013).

The Dutch and the German system, after the latest reforms of 2006 and 2007 respectively, have a lot in common. In both countries, for instance, all inhabitants are obliged to take health insurance, insurers are not allowed to refuse clients, and competition between care providers and insurance companies in terms of price and quality is encouraged. But also after 2007, in Germany some 90% of residents are still affiliated with a collective insurance fund, paying a rather low flat-rate premium, while the other 10% must insure themselves privately at much higher costs. Since 2006, the Netherlands has a unified system with only private insurers, with customers paying a much higher flat-rate premium than the majority of German citizens and insurers being required by law to offer a basic insurance package and bound to a maximum deductible (Leitner in Obinger, 2019).

As the costs for the residential home sector rise and the quality decreases, it was expected that the older residents would contribute to the healthcare costs themselves. In Germany, for example, the state introduced the so-called 'Elternunterhalt', this is a parent support (Stanco, 2016, p. 6). If the parent cannot afford the costs of the residential homes, children with an income of more than 100.000 euro are obliged to contribute to the health care costs of their parent(s). (Riedel, 2019)

Ideally, on a market, individuals are free to purchase the goods that they need or wish for. Values like autonomy and self-reliance are held high in the Dutch and German society. A person is perceived as an autonomous citizen, who can decide for him/herself how to live. Only when someone becomes unable to make his/her own decisions, for instance in the case of dementia, relatives will have to make decisions for them. But in all other cases, the idea is that an individual needs to be able to choose when, where and how (s)he wants to receive care. Most people wish to be cared for in their own home as long as possible. Only when that is no longer possible, they will move to a residential home. However, after being admitted to a care home, the autonomous citizen becomes a care-dependent resident, a resident with very little choice as to for instance who will care for him/her, or the kind of care s/he will receive.

In Germany, children are confronted with a stigmatizing discourse when they take their vulnerable and older relatives to a residential home. Good care is provided by family and not by others in care homes is the dominant norm (Horn, et al., 2021). This is in contrast to the Netherlands, where the image of residential homes is less negative and relies less on family as care providers (Horn and Schweppe, 2019).

In the last decades, because of the increase in the ageing population in European countries, older people with severe complexities can no longer stay at home, and are admitted to residential homes. According to the logic of the market, more consumers (in this case of the 'product' of health care) combined with cost efficient production due to technological innovation, would lead to a rise in labour productivity and hence to economic growth (Böcker, Bruquetas-Callejo, Horn, Schweppe, 2020; Helderman, et al, 2005). However, in labour-intensive sectors, such as health care, it does not work this way. Although the number of admissions of older residents in residential homes is growing, and more efficient work schedules and technological innovations may help a bit to get the work done, there is a certain limit to what these initiatives can do to reduce the costs while maintaining the quality of care. Health care is not a product but a service, care workers are not producers and patients are not consumers. Care workers may try to work faster or more efficiently, but beyond a certain point this does not improve the quality of their work, but may even diminish it. Unlike sectors where higher productivity enables a wage increase, in the sector of health care at a certain point an increase in wages only increases the cost price per service. Institutions like residential homes cannot moderate the salary increase too much, because then they would not be able to recruit enough staff members. This is the so-called Baumol effect (Böcker, Bruquetas-Callejo, Horn, Schweppe, 2020, p. 5). This effect makes residential homes relatively expensive. If the demand for higher quality of care increases too, for example by asking more time per patient, the services become even more expensive. That is one of the reasons that many scholars argue that a new economy is needed, where not money but care is at the centre (Hakim, et al., 2020).

Commodification and the market were introduced in the health care sector to counteract the long waiting lists, poor customer friendliness and a lack of coordination between institutions. The idea is that the market and the corresponding competition translate into accessibility, affordability and high-quality care (Canoy, 2009, p. 3). Insurers are encouraged to compete with each other and there is room to compare residential homes. In order to reduce costs, health insurance companies impose certain control mechanisms on care providers, like residential homes. Such bureaucratic tools to control and ensure what is done with institutional money, require greater accountability which in turn requires more registration (Tonkens, et al., 2013). For example, to control personnel costs, the tasks of care workers are recorded in minute lists. If one introduces market-based economics in service driven systems like residential homes, market-based values

such as productivity, efficiency and effectiveness enter. The result is that health care workers have to work faster and more efficiently within the same time, pushing professional values such as attentiveness and carefulness into the background. When they can no longer work according to their professional values, there is a risk that care workers will act thoughtlessly or call in sick. Not being able to provide sufficient care leads to a decrease in quality of care, which in turn diminishes the trust of the insurers who will then require even more accountability. But in the end quality of care cannot be accounted for in a registration system where values like productivity, efficiency and effectiveness predominate.

Since the reform of the health care sector some fifteen years ago, Dutch and German residential homes have been faced with reorganizations and years of budget cuts. Still, many residential homes have to deal with scarcity: with a lack of money and resources, a shortage of staff and a decrease in staff training. At the same time, more older residents with multiple complexity of their illness are admitted, which creates an even higher workload. Employees who cannot cope with this become demotivated, suffer from burn-outs and may eventually resign to look for better paid and socially more appreciated work. As a consequence, the older residents do not receive the care that the institutions are aiming for.

Geriatric care has been devalued for decades. This is confirmed in a recent rapport from The Social and Economic Council of the Netherlands (SER, 2021): the workload is high and the salary for care workers is about 9 percent lower than that of workers with a comparable education in other sectors (SER, 2021).

Health care workers have complained about a high workload, lack of recognition and low wages for years. Even with double jobs and extra hours (day shifts and night shift in one day), they struggle to keep their heads above water.

Caregivers want to provide good care for their older residents. However, they complain that their work is heavily scripted, and that organizational circumstances force them to provide only basic care. And in spite of their wish to enact care in a responsive and flexible way, many care workers (unconsciously) internalize institutional values like efficiency and productivity. To face the dilemmas arising from scarcity and the daily work conditions, care workers tend to simplify their performance, caring for the residents as efficiently and quickly as possible and providing only basic care, like washing, dressing and feeding. This becomes part of their habitus, through which they enforce the very system that they criticize and unconsciously pass it on to newcomers.

Integrating newcomers in residential homes: a paradoxical task

In many European countries, one of the remedies to combat the shortage of health care workers is to recruit personnel from abroad or newly arrived asylum immigrants. In the two residential homes studied here, the management had good intentions with their newcomers' project. They had two aims: not only to give recently arrived refugees a new perspective and work opportunities, but also to give established staff an 'extra set of hands'. However, the outcome was paradoxical: precisely due to the heavy workload, the projects did not reduce, but rather increase the work-related stress of the established staff.

Rather than feeling supported by the arrival of immigrant newcomers, the established workers felt that their working conditioned became more difficult. First, they witnessed how the newcomers were warmly welcomed by management, who offered them education and all the help. But because their own hard work went unnoticed, the established workers felt ignored and not taken seriously by management.

Secondly, because the established staff was expected to guide and supervise the new staff, they felt that the arrival of the newcomers burdened them with extra tasks, aggravating rather than decreasing their already heavy workload.

Thirdly, because the home had welcomed inexperienced and relatively unskilled people in the department, the established staff felt the quality of care was affected and that their own professional skills were undervalued.

The above mentioned feelings of resentment are part of a broader story: many established careworkers are part of a European population who feel that they have to work hard and make many sacrifices to make a decent living, but who have come to feel that their livelihood is threatened by the arrival of immigrants and refugees. This social discontent resonates in the way in which the established careworkers set themselves against their new colleagues. The boundaries created in the departement between 'us' and 'them', can be seen as a reflection of social developments in the wider Dutch and German society, where right-wing political parties produce a performativity powerful narrative of an imagined community of ordinary, hardworking working-class people (Williams, 2019, p. 10) who are portrayed as victims of cultural, symbolic or physical repression by government elites. These ordinary people are moreover not protected by the elite from the so-called 'tsunami' of refugees that overwhelmed Europe in 2015 (Bongiovanni,

2018, p. 31). According to right-wing parties, the European border regime is lacking and governments are too hospitable to refugees. Asylum seekers and refugees are encouraged with a welcoming policy to participate in society while they, the ordinary hard-working people, are systematically disadvantaged (Hochschild, 2016). This populist discourse resonates in the perception of some of the established caregivers in the residential homes. These caregivers echo the views of right-wing parties that current liberal governments do not care for the older residents who built up the nation after World War II.

Next to a gap between the established workers and the immigrant newcomers, in the residential homes we also observed how the established staff became more critical of management, who they felt were alienated from daily reality in the departments. These feelings resonate with the populist critique that (higher educated) politicians are not in touch with the ordinary (lower educated) citizens anymore (Noordzij, et al, 2021).

Tinkering with values, structures or cultures?

The immigrants in turn were also critical of the way care in the residential homes was organized. They likewise felt abandoned by management, questioned the professionalism of their established counterparts and wondered how they cared for the older residents. In order to cope and keep their self-esteem in the new environment, the newcomers attributed positive qualities to themselves, such as being more polite and having more respect for older people. Just like their established colleagues, they assumed that the differences between them were *cultural* differences. This process of culturalization can be understood as a process in which a person holds on to a static conception of culture (Mepschen, Duyvendak, Tonkens, 2010, p. 233), i.e. of a culture as a closed, timeless and conflict free whole, carried by people who basically share the same beliefs, norms and traditions. Culturalization refers to a discursive and interpretive framework which divides groups into different, internally homogeneous groups. This is also often put forward as an explanation why interaction between established and immigrant workers is not successful.

This view however distracts from what this study has shown that really matters, i.e. the fact that both established workers and newcomers find themselves in an environment where conditions of scarcity and bureaucratic values such as standardization, efficiency and productivity, put pressure on the work situation.

Most newcomers are eager to learn and want to absorb new knowledge and skills in order to adjust to the new workplace. They observe and imitate the behaviour of their established colleagues to get a feel for the game of care as it is practiced in these European homes. As a result, however, they unintentionally and unconsciously conform to the bureaucratic habits, norms and expectations that dominate within the residential homes, until it has become their usual way of working too. This way of working might deviate from their former habitus or even their ideals of personal care, but they come to accept it as how 'things are done here'. In other words, the effects of the marketization and bureaucratization of care will also be taken for granted in the long run by the newcomers. The complex dynamics in the daily practice of health care workers are therefore not only caused by governmental and institutional policies, but the messages conveyed by these policies are also reinforced by the daily practice of the health care workers themselves. They are captured in a circular process in which certain norms and ways of working are constantly reproduced.

In general, established workers and newcomers both wish to enact good care for the older residents. At the start of this research, I assumed that what I called 'the reversed gaze' of the newcomers could yield interesting critical insights into the pros and cons of the taken for granted routines and habits in the Dutch and German homes. I expected that the findings of such a reversed gaze would enable a critical reflection on the values and assumptions underlying Dutch and German geriatric care practice. However, in the course of research it appeared that the perspective of the newcomers was not so much different from that of the established. Overall, they subscribed to similar values of geriatric care, such as dignity, respect for the older residents, taking sufficient time, being patient, and being attentive to personal needs.

Simultaneously, the newcomers were tacitly judged by their colleagues according to standards of professionalism that may indeed be alien to them, such as taking initiative, being able 'to see the work', and showing intrinsic motivation. However, due to language difficulties and lack of mutual exchange, both groups rarely had the time and opportunity to become familiar with each others' values, norms and expectations.

In the Dutch residential home, the buddy system enabled established workers and newcomers to worked together. In such a constellation, they may learn from

each other's experiences, will have the opportunity to tinker with different values of care and find practical solutions when confronted with conflicting values or with residents who need time to make the strange(r) familiar. Moreover, the newcomers have the time to adopting a new professional habitus.

But if organizational conditions and institutional constraints make such collaboration and tailor-made support impossible, as was the case in the German home, newcomers are left to their own devices. In situations with a high workload, they have to rely all the more on the ability to tinker, for instance between values of professionalism and institutional expectations. But without the support of an experienced colleague, in stressful situations it will be difficult for them to decide what to do, whether for instance to respond to the needs of an individual resident, as their theoretical nursing training has taught them, or to work efficiently in order to master all the different tasks in the wards.

FURTHER RESEARCH AND PRACTICAL IMPLICATIONS

In order to get a more thorough understanding of factors that might contribute to a better integration of (asylum) immigrants as care workers in Western residential homes, the following topics are worthy of further investigation.

First, in order to be able to acquire better insight into general patterns of the everyday interactions between established care givers and immigrant newcomers, there is a need for more multiple site ethnographic studies in Western European residential homes. These might be more comparative in design, for instance by comparing residential homes that are similar regarding national (policy) context but different in their approach to the integration of newcomers.

Second, in order to get more insights into the way in which such projects affect the quality of care, it would be interesting to complement a similar ethnographic research design as in the current study with in-depth interviews with the ageing residents and their relatives.

Third, despite the fact that the care for people in a residential home is complex and requires a high degree of knowledge and skills, there are only a limited number of people willing to work in residential homes. This is also based on asymmetrical power dynamics. Nurses rather work in hospitals than residential homes, cure rises above care. Further research is needed for developing strategies to overcome barriers and

interventions for exploring and recruiting the potential of newcomers, refugees and asylum seekers for (re)training to obtain competent staff in residential homes.

Fourth, in the Netherlands and in Germany, some newcomers quitted within a few days. In the Netherlands, one in ten quit within a few weeks, another within a year because it did not meet his expectations, five newcomers stayed after graduation and two left after graduation for social work, one works as a freelancer in nursing care. At the time of writing, there are still three people working in the residential home. In Germany, one (out of seventeen) quitted after the first week of internships because of different expectations, four started with a nursing education after the three months of orientation, two of whom stopped within a year and started again the following year. Most applied for better paid jobs. These findings are in line with the data presented in a recent report of the Netherlands Scientific Board for Government Policy (WRR, 2021), indicating that 43% of the recently graduated nurses are leaving the sector within two years, because they cannot cope with the stress or because they are frustrated they cannot work according their own professional values (WRR, 2021). Those responsible are called upon to advocate the inherent expertise of these health care workers and to act as their ambassadors to ensure that newcomers do not drop out during the integration trajectory in residential homes.

At this moment, in the Netherlands one out of seven citizens is working in the care sector, but due to the ageing population and longer life expectancies for 2060 it is expected that this ratio should be one in three (WRR, 2021). Given the already acute shortage of care workers in geriatric care today, one of the first practical implications of the outcomes of the current study, is that it is important to implement strategies in residential homes aimed at recruiting and retaining health care staff. These strategies should be aimed at the improvement of secondary working conditions, such as more autonomy at work, more time for the actual care tasks, less bureaucratic work, more appreciation from management and better educational and career opportunities.

Second, this study has shown that, in order for immigrant newcomers to successfully integrate into the workforce of a residential home, i.e. to develop the required professional habitus and a feel for the game of geriatric care, the institutional implementation of a support network is of the utmost importance. Not only to ensure the quality of the care, but also to create a mutual understanding between

the established workers and the newcomers. Simultaneously, if the established staff are not given practical or emotional support, if they have no voice or choice, but instead are faced with unreasonable demands, this will lead to resistance, even refusal to coach their new colleagues. In the current situation where residential homes struggle with scarcity of personnel, time and resources, both established workers and immigrant newcomers constantly need to tinker between efficiency and attentiveness, between institutional rules and professional values, between standardization and flexibility.

Thus, in order to improve the care for the older residents, a social support network for both established and new caregivers is vital. This allows for the expression of hybrid professional identities, where both established staff and newcomers learn to navigate between, and mix elements from the various work cultures they are familiar with.

Third, when it comes to improving the conditions under which recently arrived immigrants may be recruited and retained in the workforce, results of the current study emphasize that fostering teamwork is needed. Workforce integration can only be successful if all staff, established as well as newcomers, receive good guidance and support networks. Language classes for newcomers should be an important part of their training, in order for them to gain a better understanding and mastery of all the nuances and metaphors in the new language. Cultural competency courses for both established workers and newcomers, such as given in the German residential home, could be an educational aspect that adds to mutual understanding. However, courses alone are not a guarantee for successful sustainable collaboration in teams. Although the course given in the German residential home enhanced the established workers' understanding of for example different socializations, the risk of essentialism, i.e. that caregivers start perceiving the identity of others as static and fixed, should be avoided. It is also important to make them alert to their own and others' multiple identities, i.e. that individual identities are always in the making, that they are never finished but may change by displacement in time and space (Belt, et al., 2015, p. 106; Çankaya, 2020; Hoffman and Verdooren, 2018).

Findings in the Dutch home, where the established were not offered a course in intercultural competency, show how important it was for newcomers to be able to collaborate with and receive guidance from an established worker. Such a set

up where established staff are invited to act as 'buddies' also leads to a greater commitment to the integration project. Instead of endlessly distinguishing between established care workers who lack intercultural competences and newcomers who have deficiencies and need (re)training, we better ask ourselves how we can create 'politics of care', i.e., the optimal conditions in order to care for our environment, our people and our vulnerable others (Hakim, Chatzidakis, Littler, Rottenberg and Segal, 2020; Raworth, 2017). Putting care first means that we humans need to recognize and embrace our interdependencies. Above all, our capacities cannot be realized in an indifferent world.