Good professional care in times of superdiversity

Client experiences of home care in the Netherlands

Paper presented at the Transforming Care Conference 2019
Copenhagen, 24-26 June 2019

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1. Introduction

Europe is experiencing population ageing and an increasing number of seniors have a migrant background. We live in an age of 'superdiversity', writes Vertovec (2007; Meisner and Vertovec 2015). People come from many different countries and we see marked differences, in terms of educational background or generation, even between migrants from the same country of origin. The resulting superdiversity raises new challenges for healthcare provision in the welfare states of Western Europe (Phillimore 2015; Schrootten et al. 2015; Karl and Torres 2016).

Although policy in many European welfare states is for people to live in their own homes for as long as possible, various Dutch and pan-European studies reveal that migrants make relatively little use of domiciliary care services (Karl and Torres 2016, Van Dijk 2012, Van den Berg 2014). Various reasons for this have been suggested. Perhaps migrants favour informal, family care to that provided by the government (Schans 2007). However, their children – the second generation migrants – may have different ideas, wishing to have time for their career and their own children (Schans, 2007, Yerden 2013). Some migrants, such as refugees, may not have any family members nearby. Another explanation could be lack of information and awareness concerning home care, or the (perceived) high cost, or the mismatch between what home care organizations offer and the demands of people in need of help . The question is whether the welfare state, and in particular the professional domiciliary care sector, is in a position to offer 'good care' to all members of the community in times of superdiversity. And what exactly does 'good care' entail?

This paper which is concerned with these questions is based on the perspective of the clients who receive care at home. What do they understand by 'good professional care'? What are the views and experiences of people from different backgrounds? In this paper, care is treated as a relational process; it cannot exist within a vacuum or be provided by one person acting in isolation. It involves interaction between two or more people (Mol 2008). Our research is therefore not only based on interviews examining the ideals, preferences and experiences of 36 individual care clients, but has also involved 'shadowing' professionals for a total of some 100 hours over a period of 16 days to observe interaction with clients in the home setting. The professionals and clients represent two separate domiciliary care organizations active in several superdiverse neighbourhoods of The Hague, a large city in the Netherlands. Not all have a migrant background: interviews and observations also involved some 'native Dutch' respondents, since superdiversity is not reserved for migrants but includes everyone.

2. How will superdiversity affect professional care?

In recent years, the concept of superdiversity has attracted much attention in various social science disciplines. The prefix *super-* refers to the increasing diversity of the overall population

because of migration. There is, as it were, a 'diversification of diversity' (Hollinger 1995: in Wessendorf 2014). Rather than large groups of migrants from just a few countries, society now includes representatives of many different countries. The Netherlands is now home to no fewer than 223 nationalities (Jenissen et al. 2018). In addition, there are marked differences between migrants from one and the same country. People have different motives for relocating (employment, political situation, family reunification, etc.) and there are differences in terms of gender, socioeconomic status and education. The position of a Polish migrant picking tomatoes cannot be compared to that of a Polish lawyer at the International Court of Justice in The Hague.

Of relevance to care provision are also the significant differences between generations, not least in terms of attitudes and expectations. While Turkish and Moroccan seniors often cherish the hope that their children will care for them in their later years, their daughters wish to pursue a career and therefore prefer to combine care responsibilities with work (Schans 2007, Yerden 2013, Van den Berg 2014). In other words, people of the same nationality or ethnic background do not form homogenous groups in terms of their values, cultural repertoire, knowledge, skills, opportunities and identities (Crul 2016: p. 58). Of course, exactly the same applies to the 'native' population, which shows a similar degree of heterogeneity in all areas. In more general terms, superdiversity is, therefore, a reflection of individualization and the development of personal identities (see also Geldof 2013).

'Superdiversity' is primarily of value as an analytical concept. It should not be seen as an ideal or normative concept (Geldof 2013). There are several potential hazards, such as a tendency to romanticize differences (Arnout and Spotti 2014) and a failure to acknowledge the differences in power and influence between the indigenous population and the 'newcomers'. If we are all 'diverse', those differences are pushed into the background and little attention is devoted to inequality, whether that between individuals or between individuals and the institutions of mainstream society (Back and Sinha 2016; Foner et al. 2019).

The application of superdiversity as an analytical concept does have certain advantages, however. It helps us to avoid examining healthcare services through a simple, static lens – something that many researchers have warned against (Torres 2015). In addition to migration background, factors such as education, generation, socioeconomic background and gender combine to form what Crenshaw (1989) terms 'intersectionality'. Another advantage is that the analysis of the superdiverse society will also include people with no migration background: the 'natives'. Research and theory relating to care provision within a (super-) diverse society must not be confined to the migrant communities but must also include the indigenous population and consider the diversity within that population.

Vertovec regards superdiversity as a concept which should not only be used to determine the research framework, but also as the driver of change in public service provision.

According to Bradby et al. (2016: 4): "whether the concept of superdiversity becomes a useful description of the political dynamics of citizenship to inform public service provision hinges on the degree to which people – experts, legislators, opinion makers – are capable of imagining the levels of complexity that characterize the real social environments in which people integrate."(See also Blommaert 2013, p. 195).

Philimore (2011) notes that the complexity inherent in superdiversity makes the processes of consultation, indication and effective care provision more difficult. She draws attention to two specific problems, 'novelty' and 'newness'. Novelty is the result of an increasing number of small groups migrating to Western Europe from many different countries. The members of these groups do not know how the healthcare system works. Indeed, the very concept of a healthcare system is unfamiliar to them: they lack the 'cultural healthcare capital' (Shim 2010) which would enable them to make contact with professional care services. For their part, the professionals can not be aware of all backgrounds and the possible implications. The second problem is that of 'newness'. The traditional, established care system assumes that people stay in one place for long periods of time, if not for life. It does not allow for extreme mobility. Migrants, however, are now likely to relocate more often, either moving within the same country or to another country altogether. In short, the current healthcare system assumes a homogenous, static population but the reality is very different.

Green et al. (2014, p.1209) stress that, in times of superdiversity, 'navigational assistance' is of prime importance. Clients need "advice on a range of symptoms, ailments, therapies, and treatment locations; facilitation with access to care (including making contact with services, companionship and transport; financial or material help; linguistic and conceptual assistance to access and engage with healthcare at critical moments." There must also be a different form of interaction between care provider and client, in which the person's individual background is taken into account but is not the dominant factor. According to Bradby et al. (2017), professionals must learn "how to stay aware of the values that are important to individuals via interpersonal negotiation and avoid stereotyping, while attending to the protocol."

Studies such as these confirm that superdiversity makes care provision more complex. It demands an open and personalized approach, and more effective contact with the 'unaware' client who requires navigational assistance. These are all important points for attention. Whether the superdiversity created by migration also raises challenges in terms of the everyday form and structure of care services, or the values and expectations of clients, is not so clear cut. What does superdiversity mean in terms of a 'new imaginary of good care'? There is a danger that the negative aspects of superdiversity will dominate, whereupon the positive opportunities to redefine care will go unseized (cf. Philimore 2011). For this reason, this paper examines the

ideals of various individuals: How do they define 'good professional care' and what implications does this have for professional domiciliary care services in Western European welfare states? Is superdiversity a useful concept in this context? (See also Bradby et al. 2017.)

We adopt a broad definition of 'care' and 'care services'. Both terms imply a relationship between people: an interaction between the client and the professional. For that reason, 'good' care can not be encapsulated in words alone – what people say they consider important. Their actions are also relevant and our research therefore also examines day-to-day practice. Whether that practice is an exemplar of 'good' care is sometimes difficult to determine. Some interactions are clearly less successful than others. It is very obvious if there is no human 'connection': interaction is superficial and appears to have little meaning for either party. Good care relies on what Collins (*Interaction Ritual Chains,* 2004) describes as "situational entrainment (intense involvement in, and commitment to, the interaction) which in turn produces solidarity, shared identity and tangible emotional energy[i]. The minimum requirement, Collins contends, is that each party acknowledges the other as an individual, as someone with a 'biography' (p.84). In this paper, we analyse whether this is the only precondition of good care in times of superdiversity.

3. Case studies, locations and methods

To examine the experiences of various care recipients, the researchers conducted extensive observations ('shadowing') as well as interviews with clients of two domiciliary care organizations, both of which are active in superdiverse neighbourhoods of The Hague, a city in the western Netherlands. With a population of 510,000, The Hague is the country's third largest city (after Amsterdam and Rotterdam) and has the highest level of superdiversity in the Netherlands, as measured using the Herfindahl-Hirschman Index (Jenissen et al. 2018). Over half the population (53%) have a migration background[ii]. There is a relatively large Indonesian community, the first generation migrants having relocated to the Netherlands following independence in the late 1940s. They were joined by Turkish and Moroccan 'guest workers' in the 1960s and beyond. Surinamese migrants (mostly Indo-Surinamese of Asian ancestry) arrived following the Surinam's independence in 1975. Poland's accession to the European Union in 2004 saw an influx of Polish migrants who found employment in the fields and horticultural glasshouses of the nearby Westland region.

The Hague has a high level of social segregation along ethnic lines. In some districts, such as Schilderswijk and Transvaal, 80 per cent to 90 percent of residents have a migration background. These are two of the four superdiverse districts in which our research was conducted, the others being Moerwijk and Regentessekwartier. All have a relatively high

proportion of low-income households. The research was organized with the assistance of two domiciliary care organizations which differ from each other in various ways. To preserve confidentiality, we use the pseudonyms *Theresa* and *Kings Care*. Theresa is a large-scale organization which has been active in domiciliary care for many years. Its clients in the study districts are predominantly of Dutch origin, except from a number of Surinamese clients, although its staff represent many different nationalities. Kings Care was established more recently, originally with the intention of having only Turkish personnel and Turkish clients. Today, however, both the payroll and client group are more diverse. Involving this organization in our research was crucial because many of the established domiciliary care organizations in the Netherlands have very few clients with a migration background.

A total of 36 clients (men and women alike) were interviewed, of whom 17 are of Dutch origin and 18 of various other backgrounds, including Turkish (11), Moroccan (2), Surinamese (4), German (1) and (mixed) Pakistani (1). The majority of interviews were conducted in the client's own language. In a number of cases, the client's informal carer played an important part during the interview, most of them their partner. Most interviewees are of lower socioeconomic status, although there were exceptions who were middle class, mostly among the Dutch and Surinamese-Dutch interviewees. One interviewee falls into the higher SES classification. Because it was decided to conduct the interviews in the client's own language, Turkish clients were interviewed by a researcher of mixed Turkish and Dutch heritage (who also translated the transcripts), while Dutch clients were interviewed by a Dutch researcher. This approach enabled people to speak more freely. The interviews took around 1 hour.

The study also relied on 'shadowing', whereby interactions between the professionals and their clients were observed by one or more researchers, who would also ask questions when appropriate (Macdonald 2005). The observations covered just over 100 hours (equally split between the two organizations, over the course of 18 days) and involved a total of 138 visits, taking 5 minutes to 1,5 hours. Shadowing is an effective research method because it offers an opportunity to ascertain whether the professional ideals espoused by the organizations are reflected in practice. Researchers also spoke at length with various professionals about care provision in times of superdiversity, which is described in a separate report (see Kremer 2018). Fieldwork with Kings Care was carried out between September 2016 and June 2017; that with Theresa took place between July 2017 and February 2018.[iii]

Long-term care in the Netherlands

The Dutch arrangements with regard to long-term care, which includes domiciliary care, are so complex that the average person might have difficulty navigating the system, let alone more vulnerable citizens or those with limited 'health skills' (WHO). At the most basic level, we can

state that domestic help and societal support (such as informal care groups) are funded by local authorities under the provisions of the *Wet Maatschappelijke Ondersteuning* (Social Support Act). Clients pay an income-related contribution. The costs of personal care, such as dressing wounds or assistance with bathing, are covered by standard health insurance (which is mandatory: everyone resident in the Netherlands must have health insurance). There is likely to be a personal contribution or excess, depending on the terms of the policy. It is possible to claim all or part of the cost of intensive, long-term care (such as round-the-clock attendance) under the *Wet Langdurige Zorg* (Long-term Care Act), which is funded from general taxation. Any personal contribution is based on the client's income. Domiciliary care organizations receive payment in respect of some (most) of their clients from the health insurance companies, and the remainder under the Long-term Care Act. If they provide domestic help or social assistance (e.g. helping a client to complete forms), they are paid by the relevant local authority. In some cases, clients can claim a personal budget with which to purchase care services. The care requirement is assessed by the municipal district nursing service but the client is free to select and engage the preferred provider(s). The current research is concerned with the type of personal care that is usually funded by health insurers or, less often, under the Long-term Care Act.

4. Superdiverse clients, superdiverse professionals?

A common response to the rapidly changing demographic make-up of society is to engage care providers of similarly diverse migration backgrounds. The underlying belief is that people can best be cared for by others of the same background, who are likely to be more empathetic, able to communication more effectively, and will better understand the client's wishes and expectations. If this is indeed the case, we might assume that natives are better served by native professionals. Moreover, as Bradby et al (2017) note, in today's superdiverse society it is becoming increasingly difficult to match client and healthcare professional on the basis of migration background. Even Kings Care, which has a relatively high number of Turkish and Moroccan staff, is not always able to do so. The majority of Theresa's clients are of 'native' Dutch origin but the organization itself has an extremely diverse workforce, including careworkers from Thailand, the Caribbean region and Iraq, but relatively few from the Netherlands.

To what extent does the ethnicity of care providers actually matter to their clients? People are unlikely to bring up the question of careworkers' migration background unprompted. During our interviews, however, clients were specifically asked whether it is relevant. Most natives did not consider it particularly important. "They pull up my stockings just the same as anyone else". Some people admitted to having had misgivings at first. Their doubts were dispelled once they had actually met the careworker. This eventual indifference even applied to those who had previously felt 'out of place' in their neighbourhood and had made

comments such as “Am I still in the Netherlands?”, “It’s like little Turkey around here”, had complained of ‘too many headscarves on the street’, or had compared their Muslim neighbours pejoratively to ‘penguins’ (a reference to the wearing of the burqa). This is in line with the contact hypothesis which states that direct interpersonal contact can be an effective way of reducing or eliminating prejudice based on differences such as ethnicity. The other person is seen as an individual rather than as a member of a group (Allport 1954; Pettigrew and Tropp 2006).

> “I always used to say they’re not coming in my house. But I certainly wouldn’t say that now. I’ve never known a ‘headscarf’ to do anything wrong or refuse to do something when asked. I am being helped exactly the way I wish to be helped. We are, of course, of a generation who still find this a bit strange. But they are very conscientious people. And very polite, very well brought up.” (R19T)

This reluctance, however, is nevertheless sometimes felt by careworkers with a migrant background, which they often wave away as not being important and something that will pass away (except when blatant racism occurs). Native clients, on the other hand, are sometimes afraid to talk freely and talk apologetically when they stress differences between themselves and others (‘I don’t mean to discriminate’).

There are also native clients who explicitly welcome being cared for by someone of a different migration background. They are used to having contact with a wide range of people; they may have family or neighbours with a migration background. There is ‘common place diversity’ (Wessendorf 2005). Some even have a strong preference for careworkers of a different ethnic background, finding them more cheerful or more compassionate (“she has her heart in the right place”), or because they enjoy hearing different perspectives. “You learn things – it gives an extra dimension to the meeting.” This cross-pollination can also be seen in other types of interaction, such as that between careworkers with a migration background and educated, well-to-do native clients, or between careworkers with a migration background and those from the ‘working class’. As one interviewee (R17T) puts it, “Real working class people from The Hague, whether from Scheveningen, the Philippines, Surinam or Aruba – everyone is really nice.” There is clearly a wide variation in the responses of natives to superdiversity (see also Van Wonderen and Van Kapel 2017).

First generation migrants, i.e. those born in another country, are more likely to have a strong preference for a careworker from that country. This is often the case among people from Surinam and the Netherlands Antilles, who may feel a certain nostalgia for their homeland and therefore enjoy talking about matters which are relatable only to those from the Caribbean region. The same preference was expressed by a client of German origin, who enjoyed speaking German with the careworker and discussing German television programmes. Turkish clients are

especially likely to state that their compatriots are more empathetic and warm, and believe that Turkish careworkers will do more for them. They find native careworkers to be more businesslike. A small number of clients, mostly Turkish, state that they would even prefer not to have any 'foreigners' involved in their care, a group which they include the 'Dutch'. Some Turkish interviewees use the word *yabanci,* which also means 'strangers' or 'outsiders'. These migrants can feel particularly vulnerable, especially since they are not proficient in the Dutch language.

Contrary to claims made in the societal and political debate, the majority of clients do not regard ethnic or religious background as an important aspect of good care. Rather, they simply wish to be able to communicate in their own language (see also Suurmond et al. 2015, Phillimore et al 2018). Almost three out of four of the Turkish and Moroccan seniors we encountered during our research speak little or no Dutch. Even those that do are more comfortable speaking their own language when they are feeling sick or weak.

> I: Did the fact that Kings Care is Turkish influence your choice?
>
> R: Yes, of course. At least I would be able to communicate with them, I thought. I came here [from Turkey] and have never been able to learn a word of Dutch. I can't even answer a simple question in Dutch and I do not have any Dutch friends or neighbours. […] I never want a foreigner, I always want a Turkish careworker. I can understand her, and she can understand me. […] A headscarf is not important […] as long as she is personable. My careworkers must be open and honest, just as I am. (R10K)

Conversely, clients of Dutch origin can sometimes be irritated by the limited language skills of careworkers from other countries. This applies not so much to Turkish and Moroccan staff, many of whom were born and raised in the Netherlands, but to more recent arrivals from Thailand and the Philippines who make up a large proportion of Theresa's staff. The language barrier is a source of frustration:

> "If I'm not feeling well and she's sitting there talking nonsense, or at least it's nonsense to me because I can't understand her, I think 'oh, just shut up, girl. That's enough, I can't be bothered.' What I actually say is, 'I'm tired'. (R12T)

Clients must sometimes repeat themselves several times, while occasionally the careworker remains unaware that there has been any miscommunication. This can result in serious problems: a careworker who panics, cannot read the instructions of medications properly, or injures the client when attempting to wash her neck.

Language and spoken communication are elements of the quest for commonality. Because the professionals interact with clients in their own homes – their private domain – and because care is not merely an action but a form of relationship, both clients and professionals must seek common ground and a shared frame of reference. This will not only increase the

client's trust in the careworker but will ensure that both have something to talk about. Popular television programmes are a useful topic of conversation, as are food and cooking. Where there is no common ground and no interpersonal relationship, the quality of care will inevitably suffer.

> "You have more contact if you talk about food. Most of the careworkers are Surinamese and I don't eat that sort of thing. So we have no contact about food and eating. With Dutch careworkers I could talk about hobbies, but often they don't have any hobbies of their own. I would like to chat about a certain topic but they don't know anything about it." (R9T)

This lady finds it difficult to establish common ground, partly due to differences in ethnic background but also because of differences in education or social class. One highly educated client reported that he sometimes has difficulty understanding his 'Dutch' careworker: "she never finishes a sentence." However, it is not all about being able to understand what the other person is saying: "He or she has not learned very much and is, therefore, not able to hold a meaningful conversation. It's not a great problem for someone to have limited education if she can wash you properly, but it is a problem if she wants to talk while she's doing it." (RT19)

Topics which emphasize differences between client and careworker are best avoided, a prime example being politics. There have been instances of friction between Turkish clients and their Turkish careworkers who did not see eye to eye about Gulen and Erdogan. Some clients report disagreements about religion, the Dutch 'Zwarte Piet' tradition and even migration. "We just make small talk. We do not discuss religion because that would only lead to arguments." (R2T)

The observations confirmed that some care interactions are indeed less successful than others. It is very noticeable when neither client nor careworker makes any attempt to develop a relationship and close social distances. According to Collins (2004), successful interaction requires each party to acknowledges the other as an individual, as someone with a 'biography'. However, good care depends not so much on the individuals' biographies as on everyday commonality. Whether that is based on little jokes, talking about hobbies or watching the same television programmes is not important. Speaking the same language does indeed help. However, the crux of the matter is that careworkers – and their clients – must be able to find common ground.

5. Superdiverse or supersimilar?

Where domiciliary care organizations devote attention to superdiversity, it is mainly in terms of religious and gender differences. It is assumed that migrants have very different standpoints compared to 'mainstream' society. Theresa has a policy of expecting all clients to accept having

a male careworker, unless there are exceptional circumstances such as past experiences of sexual abuse. Not all Theresa staff endorse this policy, believing that clients' own wishes should be respected. At Kings Care, the policy is that the wishes of female clients will *always* be respected. Female clients with a Turkish or Moroccan background would object to being washed by a male careworker, as would those with a Surinamese background and indeed most women with a Dutch background. As one 'Dutch' female client remarked, "No, I won't have it."

Most clients are quite relaxed about religion and religious differences. The majority of interviewees, regardless of ethnicity, agree with the Turkish client who said, "You have to respect someone's religion, whatever it may be. That includes Christianity. And if someone doesn't have a religion at all, that's also fine. It's up to everyone to decide for themselves" (R4K). Some Dutch clients are slightly perturbed at first by visible symbols of religion, such as the headscarf that some careworkers wear. Nevertheless, they too tend to adopt the 'live and let live' attitude. "They don't say anything about the way I dress so why should I?".

A common 'normalization strategy' among native clients is to compare the Muslim girls' headscarves with the traditional dress of Scheveningen, which also includes a headscarf. Clients who actively practise a religion appreciate having careworkers who do likewise. Not only is this a source of commonality but it may also be important for the careworker to be aware of certain customs and practices, such as Wudhu ablutions for Muslims and the fact that some Surinamese (Hindustan) families do not allow women to enter the kitchen while menstruating. The majority of clients say that they would be happy to talk about and explain their religious beliefs, adding that a respectful attitude is more important than having a careworker who is also religious.

The importance of respect extends to various other areas. Many clients with a Turkish, Moroccan or Surinamese background expect careworkers to remove their shoes when entering the house (or to wear plastic overshoes), either for hygienic reasons or because the floor must be kept clean for prayer. One client had actually switched to Kings Care after a careworker from another organization had violated this norm. Removal of footwear is more than a simple action: it shows respect for the client's home and private domain.

Respectful interaction is an aspect of good care that all clients emphasize in their interview responses, and this was also evident during the observations. No essential differences in values are apparent but there are many similarities in terms of *how* careworkers are expected to interact. Regardless of education, migration status, ethnicity, nationality and so forth, all clients expect to be treated with respect. In their stories about good care four further prerequisites of 'good' care come to the for: (1) personal attention, preferably from (2) the same careworker on each visit who will (3) take his or her time, and (4) be upbeat and cheerful. These four requirements are listed not only by clients who are satisfied with their current care but also those who are dissatisfied. The following quotes are from interviews with two Theresa

clients who are dissimilar in almost every respect but nevertheless have the same expectations about good professional care:

> "It used to be far more pleasant, more personal. Now you get four different people marching in with a 'Good morning!' Sometimes they don't even look at you but just say 'and how are you?' before opening the curtains. 'Not bad,' I might reply. Two minutes later, they ask again. They don't even remember the first time. It's because they have been taught little stock phrases." (R8T).

> "They do a wonderful job. I have had two strokes, so the care organization only sends people I know. They help me and that's what it's all about. And we always have a bit of a chat. I know they're close by." This client's daughter adds, "She always enjoys that little chat, whether it's about the news in general or the careworker's own life. She might say, 'oh, it's so busy at home and I have to go to the hospital with my husband'. We know everyone that comes here, which I find extremely valuable. On my mother's birthday, all the careworkers clubbed together and bought her a lovely card. 'They say I'm an easy one!'." (R17T+)

For many clients, a marker of 'good' care is whether the careworker will sit and have a cup of coffee with them. In other words, whether they take time for personal attention and just 'being nice'. Almost all clients report that this is not the case; their careworkers have to rush off to visit the next client on their list. In a similar vein, many clients don't like it when careworkers keep their coat on, which they sometimes do, as a visit sometimes takes only ten minutes. It gives the impression that careworkers do not, or do not want feel at home. Coats and 'a cup of coffee' are not only practical aspects of the caregiving, they are considered as signals of time and attention. Careworkers are sometimes aware of this signaling practice and, for instance, try to avoid looking at their watch to give the client the impression the careworkers takes the time.

The portrayal of good care by the clients is in stark contrast with current practice, which is marked by a scarcity of time, manpower and resources. Domiciliary care in The Netherlands has a strong focus on efficiency and is based on the ideology of New Public Management. Staff are expected to provide a predefined package of care, whereby each activity must be completed within a set timeframe: so many minutes to help the client shower, so many minutes to put on support stockings, etc. (Van Wieringen 2019). Nevertheless, care organizations and their staff are able to make a difference, albeit small. Overall, Kings Care achieves a higher level of client satisfaction than Theresa.

6. A typology of professional care realities in times of superdiversity

Views about good care show many similarities, but there are also differences between clients. If we zoom in on clients' perception of the care *relationship,* two salient ideal-typical dimensions emerge, partly the result of superdiversity among both clients and professionals. Those dimensions do not necessarily coincide with specific countries of origin but arise because people with a migration background bring different cultural repertoires, and because the actors within the relationship strive to adopt various power positions. This analysis is not only based on what people say, but also on what people do. The process is, after all, one of 'doing care'.

First, clients differ in terms of the style of professional care they prefer. Should it be more contractual (businesslike) or more familial in nature? Familial refers to a situation in which care professionals are seen as almost a family member: a daughter perhaps, or the jolly niece who pops in from time to time. Good care is then 'warm' care, ideally reinforced by physical contact such as a hug. Care and care activities are subject to a broad interpretation, to include spending time together, cooking together, helping to complete tax returns and visiting the client in hospital should the situation arise. Care is good when the care givers are, above all, kind and compassionate.

Kings Care attaches particular importance to a personal client-careworker relationship and is, therefore, more likely to demonstrate familial care in practice. Its careworkers routinely address their Turkish clients as *amca* (uncle) or *teyze (*aunt*)*, while clients might address the careworker as *kızım* (daughter) or some affectionate informal nickname. Some clients express familial feelings. For example, a respondent (12K) states "when they come in, I always say 'here are my children,' because that's how much I love them. [...] They are part of your life, you feel at ease, they're like a sister or daughter." Some Theresa careworkers (of Surinamese and Nigerian background) also address their male clients as *papa*, which could be regarded as patronising (see Karner 1998) but is generally accepted as warm and friendly.

Contractual, businesslike care is likely to comprise a set of predetermined activities performed at a predetermined time. Careworkers are not judged primarily in terms of kindness or compassion, but for their competence and effectiveness. The care relationship has clear boundaries and is not overly personal. While even the businesslike relationship calls for courtesy and respect, neither party expects it to be convivial. As one Theresa client (R2T) explains, she does not have a warm relationship with her careworkers, "...but that is a good thing. As soon as they become familiar, I put my foot down. There has to be a certain distance." This client also appreciates careworkers who do not talk too much, because then she doesn't have to answer. One Kings Care client (R2K) says something similar: "I don't know them personally. It all has to stay quite businesslike." In the contractual relationship, care is regarded as 'a necessary evil', without which the client would not be able to function at the same level. "I still have a life of my own," states one, fairly young (50) client.

Differences in this dimension affect day-to-day care practice. Clients with a more contractual attitude are inclined to take a dim view of careworkers who do not arrive at the agreed time, or when several careworkers attend on the same day. As one native respondent states:

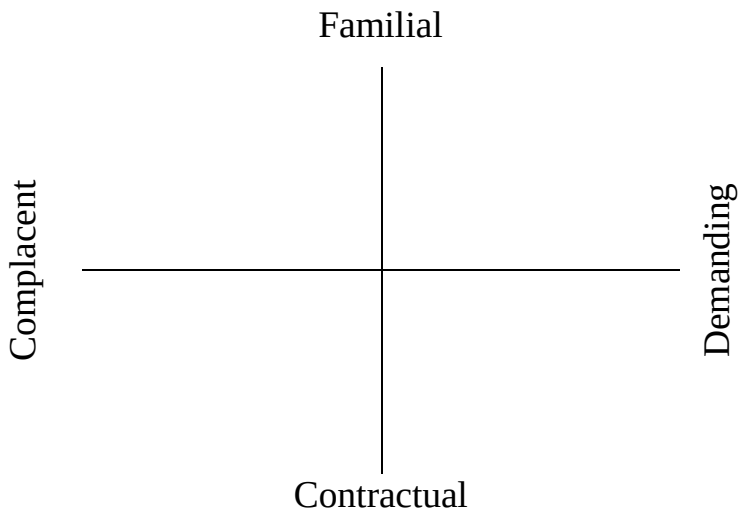
> "I'm not just hanging around waiting for a visit. I have much better things to do than sit here with my leg in the air [awaiting dressing]. I want to put my trousers on and get on with other things. When they've finished, I don't actually chase them out but I'm not going to ask them to stay for dinner either [laughs]. Some seniors like the company. They'll put the kettle on. Well, I'll make a coffee but I don't expect them to take an hour drinking it." (R4T).

By contrast, an older female respondent (from Turkish background) with a more familial relationship states:

> "I have careworkers popping in all day, to make breakfast, take blood, cook dinner and so on. And now you're here too. I think I have about six regular careworkers. Can you imagine how nice that is? It keeps me cheerful all day." (R2K)

Research (mostly conducted in North America) suggests that the family metaphor is not uncommon in professional care and more often used among staff working in the residential care setting, both careworkers in general (Karner 1998) and those from or dealing with 'minority groups' (Berdes 2007; Dodson and Zincavage 2015). Studies compare and contrast 'warm' familial care with the more technical, instrumental or 'cold' style of professional care practice (e.g. Stone 2000). By emphasizing familial relationships, it becomes possible to make a legitimate shift from 'strange' to 'affective' The family metaphor also helps to bring practice in line with the ideal off family care: "it is not my own daughter who is caring for me, but the careworker has become like a daughter to me." Highlighting this 'fictive kinship' enables clients to maintain the cultural ideal of care by actual relatives (Karner, 1989).

Figure 1. Typology of professional care



A second dimension is that of how clients and careworkers interact with each other: the 'power relationship'. At one extreme of the scale are the clients who wish to define good care and are not open to the input of the professionals. This dimension is fed by various ideological notions which have become common currency in Dutch domiciliary care. Policy, and the professionals themselves, stress that 'the client should be placed centrally'. And because domiciliary care is a market in which clients can choose a particular organization, the adage of 'the customer is always right' is frequently applied. The familial logic adds a third motto, namely that 'seniors deserve respect'. Demanding clients expect care staff to 'listen' to them, which does not mean listening to the client's preferences, but doing precisely what they are told. 'Listen' becomes a euphemism for 'obey'. Sometimes, clients will actually say, "they work for me" or "I'm their employer." People who favour the contractual relationship believe that this enhances the quality of care. "Otherwise the relationship becomes skewed. You are the client, you are in charge. I establish the boundaries. I think an overly personal relationship detracts from the quality of care." (R6T).

At the other end of the scale are the 'complacent' clients. They are happy with everything the care worker does for them and are extremely grateful. Many had never expected to be cared for at all. This applies not only to migrants from countries which do not have a professional domiciliary care system, but also to the immediate post-war generation of Dutch citizens who have seen the welfare state develop around them and are pleasantly surprised by the results. Respondents state, "I am satisfied – I am satisfied with absolutely everything" or "I will never say 'no I don't want that' or 'you're not doing that right'." Complacent clients also empathize with the care worker because she is so busy and has to rush from one address to the next. They may give the careworker sweets for her children, or listen sympathetically to her

complaints about her manager or the hectic schedule she has that day. Sometimes professionals label 'complacent' clients as 'easy going clients'.

Four types of care relationships

If we link the two dimensions, we arrive at a typology of care relationships with different interpretations of good professional care. The first is *demanding familial.* At first sight, this appears a paradoxical combination but it is actually an ideal-type that could be seen with some frequency in our research. Familial relationships are often hierarchical in nature, whereby seniors are seen to deserve respect and in some cases will demand respect. The careworker is then not only a 'dear niece' but will also do whatever the client asks. Karner (1989) states that it is by emphasizing 'kinship' with the careworker that the client is able to make demands that go far beyond the standard responsibilities of an employee. Clients show a certain avarice in demanding more than has been agreed, or more than is actually paid for by their health insurance.

An example is Mrs Ousmane, who is sprawled comfortably on the sofa, tea and cake in hand, having a nice chat with a young girl who at first sight seems to be a niece as they are laughing and touching each other but she turns out to be the professional cleaner of the home care organization. We – the careworker and me - are also offered tea and cake. Her husband is not allowed to sit with us (the care worker is coming for her, not for him, she stresses). Then she starts issuing orders to the care worker. She wants her to find a letter from the hospital in the cupboard and translate it for her. We actually came to take a blood sugar reading, but she refuses. "No, not today." (Observation).

The second type is *familial complacent.* These clients say, 'they are worth their weight in gold,' 'I'm so happy to have help', and 'anything is better than nothing. 'Or 'even if they don't provide good care, I wouldn't say anything because I'm just grateful that they come at all." The familial complacent client can appreciate the careworker's position and will adjust her expectations accordingly. "Careworkers are people too. They have to work all day, from early morning till late evening. It's not easy. They get swollen feet." (R2K). Even if the care is not in keeping with their wishes, they are unlikely to say anything that may sour the relationship. "The most important thing is that we get on well together. Perhaps that is why I never phone the office to complain." (R28K)

The third type of client is the *demanding contractual*. An example is Ms Han, the daughter of client R11T. She is indignant because the careworkers who come four times a week to help her father shower and get him ready for the daycare centre are not keeping the agreements. They do not take enough time to wash their client properly, and sometimes miss

appointments altogether. “He is entitled to a thirty-minute visit but sometimes they are only here for fourteen minutes.” This lady relies not only on the citizenship argument, whereby people have certain social rights, but also the market argument in which she regards herself as a paying customer. “Suppose I have a subscription to a newspaper. They phone me to say, ‘the delivery boy is off today so you’re not getting it.’ That’s not acceptable and I wouldn’t stand for it.” She clearly believes there to be a power relationship, as evinced by the words, “they seem to think that they’re in charge and not me – not in my own house.”

The fourth type is *contractual complacent.* These people are happy if all agreements are kept, but are unlikely to complain if they are not. They understand that things do not always go according to plan and that a careworker may be a little late. They wait patiently and are not overly concerned if things go wrong. They do not make excessive demands but they do appreciate the agreed care being provided ‘by the book’.

It is not possible to link the four typologies directly to a particular migration background, educational level, age, gender or generation. Nevertheless, the ideal of familial care is more prominent among clients with a Turkish or Moroccan background and slightly less so among those of Surinamese origin, although this is not carved in stone. The degree to which a client can be said to be *demanding* or *complacent* will sometimes depend on generation: the most senior, first-generation migrants tend to be more complacent, while second-generation migrants are more likely to be demanding. There seems to be a general assumption that vulnerable clients are more likely to be demanding when dealing with careworkers of the same migration background. It is as if the lack of status within wider society is sometimes being compensated in the home setting. Natives seem more likely to favour the contractual approach, with possible exceptions among those of lower educational qualifications who may adopt a familial relationship. The care requirement is also relevant. If only short-term in nature, as in the case of a patient receiving visits for one week following a hip replacement, a purely contractual relationship is far more likely than when someone requires daily assistance for many years.

As noted, relationships between Kings Care clients and their careworkers are more often familial in nature than those of Theresa, where the contractual relationship is dominant. As a result, Kings Care seems better able to provide satisfactory care to clients with a migration background than Theresa, and achieves a higher satisfaction rating even among clients without a migration background.

7.Conclusions: challenges for domiciliary care in times of superdiversity

Changing demographics demand a reappraisal of what ‘good care’ means in today’s welfare states. We see increasing superdiversity, with a growing number of people from a larger

number of migration backgrounds. Researchers concerned with superdiversity have stressed that a personalized approach to each client is essential. Country of origin is only one factor: gender, income and generational differences must also be taken into consideration, without falling back on stereotypes. It will also be essential to provide more 'navigational assistance' because people from various countries are unfamiliar with the complex routes within Western healthcare systems. Of course, modifications and improvements are to be made not only for the benefit of migrant communities but for everyone.

While modernization of professional care is certainly important, it must be asked whether modernization that relies predominantly on the introduction of 'customized care' is perhaps an overly simplistic response to superdiversity. This approach overlooks the fact that good care relies on interaction between two people – the client and the careworker – and superdiversity is also increasing among professional care providers.

Our research, involving interviews with 36 clients and intensive shadowing, reveals a more nuanced picture. The crux of a good care relationship in times of superdiversity is the creation of commonality between client and careworker. It helps if both speak the same language (because, for example, they or their parents are from the same country) but contact can also be made through everyday interaction such as (non-verbal) jokes and casual conversation about food or television. Good care in times of superdiversity is about closing all kinds of social distance and calls for a willingness to invest in the relationship on the part of both careworkers and clients. This everyday commonality can sometimes be a balancing act, as sensitive differences need to be neglected, from both sides.

Superdiversity, moreover, does not mean that there will cease to be any similarities between people. Despite differences in migration background, age and gender, most people will continue to endorse broadly the same ideals of good care: personal and respectful attention, preferably from the same careworker on each visit, who takes his or her time and remains upbeat and cheerful. The policy of domiciliary organizations often devotes attention to differences, such as in gender or religion, but similarities between clients are just as important. In this light, increasing diversity will not create radically different expectations in terms of good care, but may help to crystallize criticism of the existing (institutional) arrangements and identify why domiciliary care does not always meet the basic requirements set out above.

Further analysis reveals that there are both divergent ideas and differing practices in terms of the care *relationship.* The answer to the question 'what is good care?' is often to be found by asking 'what is a good care relationship?' There are, however, certain differences which must be taken into consideration. Partly due to the arrival of various migrant groups, greater value is attached to professional familial care in which the relationship is perceived as one of 'fictive kinship' and the care itself is relatively broad, warm and affectionate. This is in

contrast to the more contractual form of care, which relies on a set of pre-determined interactions. There are also major differences in terms of the perceived power relationship, whereby some clients are particularly demanding and others are very complacent.

This typology is another aid to identifying the nature of good care and may be helpful for a debate about good professional care in times of superdiversity. Should professional homecare seek the middle road between the two extremes: a balance between contractual and familial care and between the power position of professional and client? Or does a superdiverse society mean that all ends of the dimensions must be possible in modern European welfare states?

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[i] Interaction rituals in general are processes that take place as human bodies come close enough to each other so that their nervous systems become mutually attuned in rhythms and anticipations of each other, and the physiological substratum that produces emotions in one individual's body becomes stimulated in feedback loops that run through the other person's body (Collins, 2004, p. xiv)

[ii] This definition includes the children of migrants.

[iii] The research was by and large conducted by M. Kremer but the qualitative research examining care practice at Kings Care was also conducted by Baukje Prins. The author also thanks her for her contribution in an earlier stage of the project. Two interviewers of Turkish and Moroccan origins interviewed the client. Vita van der Staaij-Los assisted in the research at Theresa, where client interviews were conducted by two interviewers of Dutch background.