Migrant workers in the elderly care sector in the Netherlands

Name: Marjan Timmerhuis

Studentnumber: 3797198

Date: October 22, 2012

Utrecht University

Interdisciplinary Social Sciences

Social Policy and Social Interventions

Supervisor and first reader: Dr. B. Weicht

Second reader: Dr. B. Da Roit

Acknowledgements

This research marks the end of my master education in the program 'social policy and social interventions' at the University of Utrecht. It took some perseverance for me to successfully finish this thesis, but now I am very pleased with it. I was open for research topics when I first started thinking about the master thesis. My supervisor dr. Bernhard Weicht suggested the topic of migrant care workers in the Netherlands. It was not really a topic I had ever thought about before and my interest for the topic grew during the research process. I had to develop and use my research skills to successfully finish the thesis. I could not have done that on my own and that is why I want express my gratitude.

At first, I want to thank my supervisor dr. Bernhard Weicht for all the support and feedback during the entire process of writing the master thesis. I also want to thank Barbara da Roit for the feedback on the master thesis design and Rosanne Oomkens for her feedback on the questionnaire. I also want to thank fellow students Resy, Annelijn, Robin, Thomas, Hannah and Silvia for their feedback and support. At last I want to thank my family and friends for their support.

Marjan Timmerhuis

October 21, 2012

Summary

The population in the Netherlands and other Western countries is ageing. Consequences are an increasing number of users of elderly care provisions and an increase in the demand for care personnel (Eggink, Oudijk & Woittiez, 2010). To meet the demand for care personnel for the elderly care sector will be hard, because the ageing population also causes the labor force to shrink. In other Western countries the employment of migrant care workers has been a solution to the labor shortage in the care sector (Kilkey et al., 2010; Spencer et al., 2010). There is no or only very limited research on migrant care workers in the Netherlands and the aim of this research is to study what extent migrant care workers are present in the Dutch elderly care sector.

To what extent and in which way migrant care workers are present in the elderly care sector has to do with the care system in a country. For the Netherlands, Bettio and Plantenga (2004) found that elderly care was mainly provided by the state. But the organization and financing of elderly care in Western countries, including the Netherlands, has moved from institutional care and in-kind provision of services towards home care, private provision and cash transfers (Simonazzi, 2009; Da Roit, 2010). This has consequences for the number of migrants in the care labor force. Van Hooren (2012) classifies the Netherlands as a social democratic care regime in her discussion of care regimes. She states that there is no need for migrant care workers within social democratic care regimes. Williams (2010; 2012) focuses on the intersection between care and migration policies and states that those may conflict.

Whenever migrants do apply for a care job in a care organization, there might be reasons for the organization to hire or not hire migrants. Zanoni and Janssens (2004) found that human resource managers see migrants as a representative for their ethnic group. This could either lead to hiring or not hiring migrants based on their ethnic background. If there was dissatisfaction with a migrant within the organization, it could be that migrants with the same ethnic background are not hired anymore. If there was satisfaction with a migrant and he or she is seen as a model employee, it could be that migrants with the same ethnic background are hired with the same expectations.

The research question in this study is: ‘To what extent are migrant care workers present in the elderly care sector in the Netherlands and why do care organizations hire or not hire them?’ The hypotheses are about the trouble care organizations have with filling vacancies, the value care organizations ascribe to Dutch and foreign language skills of migrant care workers, the satisfaction and dissatisfaction with migrant care workers and the trouble care organizations have with the acceptance of foreign diplomas.

To collect data a questionnaire was set up and sent to human resource managers in elderly care organizations. 365 care organizations, of 489 care organizations in the Netherlands (CBS, 2012),

received the questionnaire and 28.8% responded. The analysis method in this study is multiple linear regression analysis with a sample size of 67 respondents. The dependent variable in the regression analysis is the percentage of migrant care workers in care organizations.

The results show that migrant care workers are present in the Dutch elderly care sector, but only as a small part of the total care workforce. The migrant care workers are mainly employed in the lowest three levels of care functions. The areas of origin of migrant care workers are North Africa, the Middle East, Eastern Europe and European countries. The results of the analysis show that the more care organizations value foreign language skills of migrant care workers, the higher the percentage of migrant care workers in those care organizations was. The results also show that the higher the population density in an area, the higher the percentage of migrant care workers in care organizations in that area.

The conclusion that can be drawn from these results is that the employment of migrant care workers is not yet a solution to the labor shortage in the elderly care sector in the Netherlands, as it is in other Western countries. However, migrant care workers are present in the Dutch elderly care sector which is unexpected for a social democratic care regime (Van Hooren, 2012). The results imply that the employment of migrant care workers can be of increasing importance for the Dutch elderly care sector. This would mean that care and migration policies have to be adjusted and care organizations would have to be open for more cultural diversity.

Table of Contents

1. INTRODUCTION

1.1 Introduction

1.1.1 Problem statement

The population in the Netherlands and other Western countries is ageing. Statistics Netherlands (Centraal Bureau voor de Statistiek, 2012) describes the 'grey pressure', which comprehends the comparison between the group of people older than 65 years and the 'productive' group of people between 20 and 65 years old. The grey pressure has increased over time, from 21.1 in 1995 to 25.6 in 2011. Risks related to the ageing of the population are the increasing costs of welfare state pensions and health services and the implications for social care (Taylor-Gooby, 2004). A labor shortage of care workers is also one of the risks related to ageing. Eggink et al. (2010) found that because of the ageing population, there will be a 1.2% increase per year in the number of users of the elderly care sector until 2030. A consequence of the increase in users of elderly care, is that the demand for personnel in the elderly care sector will increase with 1.2% per year until 2030. It will become harder to meet the demand for care personnel, because the labor force will shrink due to the ageing population (Eggink, Oudijk &Woittiez, 2010).

One of the possible solutions mentioned in the research of Eggink et al. (2010) for the labor shortage in the Dutch elderly care sector is that migrants and allochthonous people start working as care workers. In other Western countries (e.g. Germany, Poland, Portugal, Spain and the United Kingdom) there has been a growth in the employment of migrant workers for domestic and care work as a solution to the labor shortage in the care sector (Kilkey, Lutz and Palenga-Möllenbeck, 2010). In the United Kingdom, Ireland, Canada and the United States it has been studied which factors influence the demand for (migrant) care workers, which experiences migrant care workers have had and what the implications of the employment of migrant workers are for their career and for the quality of care. Spencer et al. (2010) compared the studies of the four countries. They state that in all the four countries there is an underfunded system of care provision and an underpaid sector of employment of migrants. Following from that, the underpaid migrant care workers are employed to work in the underfunded care system.

In many Western countries, like the United Kingdom, Ireland, Canada and the United States, research findings show that migrant care workers are an important part of the care sector. It is not yet known what the meaning of migrant workers is for the Dutch elderly care sector. This has to do with two problems. First, care institutions and organizations in the Netherlands publish year reports, but they are not allowed to mention the ethnic background of their workers. And second, most Dutch research is about allochthonous workers, this group includes workers that were born in a

foreign country and workers who have a foreign born father or mother. This study is specifically about migrant workers, workers that were born in a foreign country. The decision to only focus on migrant workers has to do with that this study is part of an EU-project that compares the position of migrant care workers in Austria, the United Kingdom and the Netherlands. In both the Austrian and United Kingdom is the focus on migrant workers and not on allochthonous workers. That is why this study will focus on migrant workers. In a report about the situation of the Dutch care and social services sector is mentioned that about 6.9% of the workers in the elderly care are allochthonous workers (AZW, 2011). There is not a specific study in the academic field or reports from the care sector in the Netherlands that give an overview of the numbers of migrant workers in the Dutch elderly care sector.

1.1.2 Elderly care in the Netherlands

Relevant for this research is background information about the elderly care system in the Netherlands. Da Roit (2010) describes the Dutch elderly care system in her book 'Strategies of care'. She describes that until the 1980s there was a tendency of institutionalization of elderly people. Housing and care policies were developed for convalescent and nursing homes, to take away the care responsibility from the family. Those elderly care policies were financed by the AWBZ, a national compulsory insurance. This insurance is for every citizen in need of care, not only elderly citizens.

Next, Da Roit (2010) describes that from the 1990s onwards there was a process of reform in the Dutch elderly care system. People started to believe that individuals should be more responsible for their own care and for each other. Also, it was believed that people should have more independence and choice regarding the care services they use. In 2007 there was a reform of the AWBZ, called the WMO, a new Social Support Act. Local governments became responsible for the provision of home care. As a consequence, there was marketization of and more competition in the home care sector. Costs had to be cut, and mainly home care workers experienced negative consequences like worse working conditions and lower wages (Van Hooren, 2011).

From 1995 to 2011 there was a possibility to buy home care via cash allowances, called the PGB (personal budget). The PGB was introduced to offer more choice to people in need of care and to save money (Sadiraj, Oudijk, Kempen & Stevens, 2011). Since 2012 there has been a policy change regarding the PGB. Less people are eligible for PGB and people need to accept the care offered to them by a care-office. Whenever someone is not eligible for PGB and the offered care is not adequate, there is another controlled cash allowance called VPZ (compensation arrangement for personal care) that can be used to buy care (Rijksoverheid, n.d.).

1.1.3 Migrant workers in the Dutch care system

Simonazzi (2009) describes that there has been an increase in migrant workers in de elderly care

sector in European countries. In the Netherlands there has been lack of research about migrant care workers. This research aims to find out more about migrant workers in the Dutch elderly care sector. Migrant workers are people that are willing to work in another country, in this study that is the Netherlands, than where they were born. The report 'Arbeid in Zorg en Welzijn' mentions the number of 6,9% *allochthonous* workers in the elderly care sector in the Netherlands in 2010 (AZW, 2011). The report is not scientific, however there are no sources that mention a number of migrant workers in the Dutch care sector. It is mentioned that the low number of allochthonous care workers in the Netherlands might be due to the low number of migrant care receivers or to social-cultural aspects, but it is not studied whether that is true (AZW, 2011).

Van Hooren (2011) and Ungerson (2004) give an explanation for the limited number of migrant workers in the private care sector in the Netherlands. Elderly care receivers might use their personal budget (PGB) to employ a care giver. The spending of the personal budget is controlled by the Dutch government. As a consequence, employing illegal migrant workers will be discovered and penalized. Dutch care receivers usually employ relatives or individual professional care givers instead. In other countries studied by Ungerson (2004), paying relatives for care is not possible or allowed and that is why migrant workers are hired instead of relatives. Visser-Jansen and Knipscheer (2004) ascribe the little number of migrant care workers in the Netherlands to language and cultural problems and the educational requirements for work in the formal care sector.

1.2 Aim of the study

The Dutch population is ageing, there is a growing number of users of elderly care and with that comes a growing demand for care personnel. Migrant workers have become an important part of the elderly care sector in other Western countries. The objective of this study is to find out to what extent migrant workers are present in the Dutch elderly care sector.

This study is part of an EU-project called 'Caring Labour in a Migrating World'. The objective of the EU-project is to analyze the position of migrant care workers in the elderly care sector in three different countries (Austria, the Netherlands and the United Kingdom), representing different care and migration regimes (CORDIS, 2011). This study will specifically focus on migrant care workers in the elderly care sector in the Netherlands and why they are hired or not hired by care organizations. The objective is to research from a theoretical approach the position of migrant care workers in the Dutch elderly care sector and the attitudes of care organizations towards hiring them. More precisely, this means that based on theories and foregoing scientific research expectations will be formulated to find out:

- To what extent migrant workers are present in the Dutch elderly care sector; if they work in the sector, what for work they do and where they do it.
- What the reasons are for Dutch care organizations in the elderly care sector to hire, or not hire, migrant care workers.

1.3 Structure

The design of this research is based on a general research process. An introduction and background information for the problem of this study are presented in this chapter. In chapter two literature and theories concerning care regimes, human resource managers and migrant care workers will be discussed and a research question and hypotheses will be formulated. Chapter three focuses on the methodology of the research. The chosen analysis method will be discussed and the operationalization of variables will be explained. Also, the social and scientific relevance and the interdisciplinary character of the research will be discussed. In chapter four are the results of the analysis presented. The conclusions that can be drawn from those results can be found in chapter five, together with a discussion of the research and recommendations for future research.

2. Theoretical Exploration

2.1 Introduction

As mentioned in chapter one, the aim of this research is to study why care organizations in the elderly care sector hire or not hire migrants. In international research is found that this mainly has to do with the care system present in a country. In this chapter literature and theories concerning care regimes and the fit of the Netherlands in the care regime typologies will be discussed. Also, Zanoni and Janssens (2004) studied views of human resource managers toward migrant workers. Human resource managers are the ones who decide if migrant workers are hired for care organizations and that is why literature concerning their attitudes is taken into account in this research. At the end of this chapter hypotheses and a research question will be formulated.

2.2 Care and migration regimes

The subject of migrant workers in elderly care is related to two main research fields, namely migration and care. Within these fields, researchers have tried to find typologies of regimes. In the field of migration, the theories are mainly about why certain ethnic groups migrate from one country to another (e.g. Massey, 1993 and Jennissen, 2007). Those theories do not explain why the migrants start working in the care sector of another country or why organizations in the care sector want to hire migrants.

In the research field of care, researchers have tried to identify a typology of care regimes. Bettio and Plantenga (2004) compare several European countries and identify five different types of care regimes. They identify those care regimes based on policies on informal care, care strategies for children and care strategies for elderly. For the Netherlands, they found that informal care is considered important and that the care for children is mainly privatized or informal. The care for elderly was for years mainly provided by the state in the Netherlands, almost unlike any other country in Europe. However, in recent years there has been a change in the Netherlands. The state wants less care responsibility and assigns it to the market and family spheres (Da Roit, 2010). Simonazzi (2009) has found that European care regimes have moved the organization and financing of elderly care from institutional care and in-kind provision of services towards home care, private provision and cash transfers. The research of Bettio and Plantenga (2004) and of Simonazzi (2009) do say something about the care system present in the Netherlands, but do not take into account the care labor force.

Van Hooren (2012) tries to identify care regimes which take into account the interplay

between public provisions, private purchases and family care. Her typology of care regimes does take working conditions of care workers into account, unlike other typologies of care regimes. Van Hooren's (2012) care regimes are based on Esping-Andersen's (1999) welfare regimes. The first care regime Van Hooren (2012) identifies is the social democratic care regime. Characteristics of the social democratic care regime are publicly provided care services without means tests, no demand for private care and no demand for migrant care workers. The second care regime is the liberal care regime, where the market sets standards for the social care provision and its workforce. The working conditions in the private sector are bad and that is why migrant workers are employed. Van Hooren (2012) calls this the migrant in the market type of employment. The third care regime is the familialistic care regime, the state and market are not involved in care provision or financing. Migrants are directly employed by the family to give care. Van Hooren (2012) calls this the migrant in the family type of employment.

In her article Van Hooren (2012) compares Italy, the United Kingdom and the Netherlands based on her care regime characteristics; public provisions, private purchases and family care. She finds that Italy fits into the familialistic care regime and the United Kingdom fits into the liberal care regime. The Netherlands fit into the social democratic care regime. Despite the fact that the Netherlands does have a private care sector, there is no need for migrant care workers . This is because of the main reliance on the public care system and help from family members.

Williams (2010) focuses on concepts regarding the relationship between migration and care. She states that: 'this relationship between migration and care operates on at least three different levels: the personal relations of migration and domestic/care work; state policies, regulations and discourses; and the transnational and global movement of labour' (p. 385). She states that themes such as global care chains, exploitation, agency, power and dependency, regional migration and diverse employment conditions are relevant within the relationship between migration and care. In another article, Williams (2012) describes that although regimes may intersect, it does not mean that national policies related to the regimes cooperate or add to each other. More likely it is to find tensions between the policies. For example, diplomas migrant workers received in their native country, may not be accepted in the country they migrated to. This is a disadvantage for the migrant worker and the receiving country, because in many receiving countries there is a shortage of skilled care workers (Williams, 2012). This shortage of skilled care workers is also a problem in the Netherlands (AZW, 2011).

In contrast with Williams (2012), Van Hooren (2012) states that labour migration policies only have a limited impact on the employment of migrant workers, because many migrants rely on residence permits instead of work permits. Van Hooren (2012) does mention that there are no specific policies for migrant care workers in the Netherlands and that obtaining a work permit is

difficult. Spencer et al. (2010) found that migrants are bound to the organization where they work, because they are dependent on the temporary work visas which they got through that organization. Migrants in the Netherlands from outside the European Economic Area (EEA) and from Romania and Bulgaria need an employment permit, which can be requested by employers (Wet Arbeid Vreemdelingen, n.d.). Being bound to one organization might prevent migrants from switching jobs, which makes it harder to reduce the labour shortage in the care sector.

Even though Williams (2012) is right about the conflicting national migration and care policies in Western countries, it is found that there has been a growth in the employment of migrant workers for domestic and care work, even when employing migrant workers is illegal or when familialisation in society is high (Kilkey, Lutz and Palenga-Möllenbeck, 2010). Anderson (2001) and Spencer et al. (2010) describe reasons why employers in the elderly care sector in Western countries are hiring migrant workers. Spencer et al. (2010) found that employers state that they do not pay migrants less than native workers or that migrants have other working conditions. Employers have to hire migrant workers, because native workers are not willing to do the low-wage work with unfavorable conditions. That is also why young people who enter the labor market are not willing to work in the elderly care sector according to Anderson (2001). Mainly the low qualified care jobs are low-wage jobs with unfavorable conditions and in the (non-scientific) Amsterdam research was found that allochthonous workers are overrepresented in the low qualified jobs (SIGRA, 2008). They are mainly there to assist or help other care workers. Both the SIGRA report (2008) and Van Hooren (2011) do not give an explanation for this overrepresentation. Visser-Jansen and Knipscheer (2004) expect that it has to do with the educational levels of the migrant workers.

2.3 Human resource managers

The main focus of this study is the question why care corganizations in the Dutch elderly care sector do hire or not hire migrant workers. Zanoni and Janssens (2004) studied the attitudes of human resource managers towards diversity management. Human resource managers are within care organizations responsible for the hiring of care-employees and they are the ones who will be asked to fill out the questionnaire for this study. Zanoni and Janssens (2004) conducted interviews with human resource managers. Human resource managers talk about a diverse employee group in two ways. First, they consider a certain employee as a representative or a member of a certain reference group. For example, one migrant worker is a representative of the entire migrant employee group in an organization. Second, they compare different groups to each other. For example, the migrant employee group is compared with the native employee group. In both ways, individuals and groups

are defined by given essences, such as ethnic background or age.

Zanoni and Janssens (2004) further found that 'different' employees are considered unsuitable for jobs, because of their given characteristics. For example, if human resource managers have hired a migrant worker and it turns out that problems arise because of inadequate language skills, the human resource managers tend to not hire migrant workers with the same ethnic background anymore. Zanoni and Janssens (2004) also found that 'different' employees can have a model function according to the human resource managers. Whenever this is the case, human resource managers might try to hire more employees with the same characteristics as the different, but model employee.

2.4 Hypotheses

2.4.1 Filling vacancies

Part of the question in this research is what reasons care organizations in the Netherlands have for hiring or not hiring migrant care workers. Van Hooren (2012) developed a care regime typology which takes migrant care workers into account. Her findings are that the Netherlands fits best into a social democratic care regime, with a private care sector. Van Hooren (2012) states that there is no need for migrant care workers in the Netherlands, because of the main reliance on the public care system and help from family members. However, there is a shortage of skilled care workers in the Netherlands (AZW, 2011; Eggink, Oudijk & Woittiez, 2010). In several international studies is mentioned that employers in the elderly care sector hire migrant workers, because not enough native workers are willing to do the low-wage work with unfavorable conditions (Spencer et al. 2010; Anderson, 2001). Further, Vernooij-Dasssen et al. (2009) studied why people quit or avoid jobs in dementia care. They found that people quit because of a lack of job satisfaction. Care workers were dissatisfied by the quality of care they could give and by the lack of appreciation. The shortage of native care workers might be a reason for care organizations to hire migrant care workers. I expect that the harder care organizations find it to fill vacancies, the smaller the percentage of migrant care workers will be in those organizations (*hypothesis 1*). This is expected, because if care organizations already do hire migrant care workers to reduce the labor shortage, they will find it less hard to fill vacancies and the consequence of that will be a higher percentage of migrant care workers in the care organization.

2.4.2 Dutch language skills

Spencer et al. (2010) found for the United Kingdom, Canada, the United States and Ireland that problems related to migrant care workers were, among other things, due to inadequate language

skills. For the Netherlands, Visser-Jansen and Knipscheer (2004) expect that employers are not willing to employ migrants for those reasons. Zanoni and Janssens (2004) found that inadequate language skills can be a reason for not hiring migrant workers. Language differences might cause misunderstandings between care workers and care receivers and between cooperating care workers. Consequences of misunderstandings might be errors in the work done by the migrant care worker or friction between the care receiver and care worker. Care organizations might expect adequate knowledge of the Dutch language from migrant care workers, because of the importance of good communication on the worklfoor. I expect that the more care organizatons value Dutch language skills, the smaller the percentage of migrant care workers will be in those care organization *(hypothesis 2)*.

2.4.3 Foreign language skills

Cangiano et al. (2009) mention that foreign language skills can be an advantage, because allochthonous care receivers can have trouble with communicating with native care workers. As a consequence, allochthonous care receivers might receive inadequate care. The foreign language skills of migrant care workers can be a solution for that problem. This is also in line with Zanoni and Janssens' (2004) findings that migrant care workers can have a model function. In this case, the model function of the migrant care worker is due to his or her foreign language skills. I expect that the more care organizations value foreign language skills of migrant care workers, the higher the percentage of migrant care workers will be in those organizations *(hypothesis 3)*.

2.4.4 Satisfaction with migrant care workers

Next to inadequate language skills, Spencer et al. (2010) mentioned that cultural differences were cause of problems regarding migrant care workers. It is hard to define what cultural differences incorporate. The ideas of human resource managers about advantages and disadvantages of migrant workers are often related to cultural differences. Zanoni and Janssens (2004) research points out that the ideas of human resource managers about migrant workers might influence the hiring of migrant workers. For example, a migrant care worker might have a work attitude that is different from the work attitude of the Dutch workers. As a consequence there can be friction between colleagues. The ideas of human resource managers about the work attitude of migrant workers might be a reason why they are not hired. I expect that the more care organizations are dissatisfied with the functioning of migrant care workers, the smaller the percentage of migrant care workers in the organization will be (*hypothesis 4*).

Zanoni and Janssens (2004) also found that care workers with a different cultural background can have a model function toward other employees. Human resource managers might hire migrant care workers with about the same cultural background for this reason. I expect that the more care

organizations are satisfied with the functioning of migrant care workers, the higher the percentage of migrant care workers will be in those organizations (*hypothesis 5*).

2.4.5 Diploma acceptance

Williams (2012) describes that there can be tensions between migration and care policies. She mentions that diplomas of migrant care workers from their home country may not be accepted in the migration country. In the Netherlands there are two institutions that evaluate foreign diplomas (DUO, 2012). Van Hooren (2012) states that there are no specific policies for migrant care workers in the Netherlands, but that obtaining a work permit in general is difficult. Even though the migrants may have the knowledge and skills for care work it can be that employers cannot hire them for those jobs, because the diploma cannot be accepted or because there is lack of a working permit. I expect that the harder care organizations find it to get foreign diplomas accepted, the smaller the percentage of migrant care workers will be in those organizations *(hypothesis 6)*.

2.5 Research question

The problem that has been the cause for this research has been described in chapter one, namely the process of ageing in the Dutch society and its consequence the labor shortage in the elderly care sector. It is shown that in other countries the employment of migrant care workers has been one solution for the labor shortage problem (Kilkey, Lutz and Palenga-Möllenbeck, 2010). Following theories about care and migration regimes and international and Dutch research about migrant care workers, I have formulated six hypotheses about migrant care workers in the Netherlands. To be able to reach the objectives of this study, a research question has been formulated: *To what extent are migrant care workers present in the elderly care sector in the Netherlands and why do care organizations hire or not hire them?*

Following this research question, several more specific sub-questions have been formulated:

- *How are migrant care workers present in the Dutch elderly care sector?*
  - What are their background characteristics?
  - Which care work are they doing?
  - In which care organizations are they working?

- *Why do care organizations in the Dutch elderly care sector hire or not hire migrant workers?*

3. Research Design

3.1 Introduction

This chapter is about the research design, including methodology, operationalization, social and scientific relevance and the interdisciplinary character of the study. In section 3.2 the research population, data collection and the analysis method, in short the methodology, of the study will be discussed. The operationalization of the dependent, independent and control variables will be discussed in section 3.3. In section 3.4 some observations concerning correlations and missing values will be discussed. The scientific and social relevance of the study is explained in section 3.5 and in the last section, 3.6, the interdisciplinary character of the study is explained.

3.2 Methodology

3.2.1 Research population

The research population consists of human resource managers working in care organizations in the elderly care sector in the Netherlands. Those care organizations are either home care organizations, convalescent homes or nursing homes, or a combination of those three forms of care. The questionnaire was sent to human resource managers, because the questions are about employees in the care organizations and human resource managers are the ones who decide which applicants are hired. Asked of the human resource managers is not to answer from their own point of view, but from the point of view from the care organization. This is done because the interest of this study is not to find out how human resource managers think about migrant care workers, but how the care organization thinks about and values migrant care workers.

3.2.2 Data collection

For the Netherlands there is no data available concerning migrant care workers. That is why a questionnaire was set up (see appendix 1). The questionnaire contains questions about the care organization, about the number of migrant care workers in the organization, their function and background characteristics, questions about the acceptation of foreign degrees, about filling vacancies and about recruitment of migrant care workers.

In the Netherlands were in 2010 about 489 organizations within the elderly care (CBS, 2012). The questionnaire was sent to 365 care organizations via e-mail, all members of Actiz. Actiz is an organization for care entrepreneurs in the sectors youth care, maternity care, home care, convalescent care and nursing care. It was chosen to contact members of Actiz, because it was the

only organization that had information on the majority of elderly care organizations in the Netherlands. Only the care organizations within the sectors home care, convalescent care and nursing care for elderly were selected. 105 care organizations filled out the questionnaire. This is a response rate of 28.8%. And about 21.5% of all the elderly care organizations in the Netherlands has responded.

3.2.3 Method of analysis

The method of analysis for this study is multiple linear regression analysis. This method will be used because it will show possible relationships between the dependent variable and the other variables. Multiple linear regression analysis is the best method for analyzing the available dataset.

Several models will be analyzed. The first model will only include the control variable 'population density'. Then per model one of the other variables will be added. In the second model this will be the variable 'foreign language skills'. The decision to add this variable as the second in the analysis, has to do with the correlations presented in section 3.4.1. Both the variables 'population density' and 'foreign language skills' have significant correlations and in the analysis it will be interesting to see what happens when those two variables are put together in an analysis.

Tables with results of the multiple linear regression analysis will be presented. In those tables are several scores shown, namely the constant, the *B*, the *N* and the *Adjusted* R^2. The constant shows what the score is on the dependent variable when all the scores on the variables included in the model are 0. The *B* is the regression coefficient of every independent variable and shows the difference in the dependent variable whenever the score on the independent variable changes. The *Adjusted* R^2 shows the total explained variance of each model for the entire population and not just for the sample. The sample size for every model is presented as *N.*

3.3 Operationalization

3.3.1 Dependent variable 'percentage of migrant care workers in care organizations'

The dependent variable in this research is the number of migrant care workers that are currently working in care organizations. Using this dependent variable will help to analyze whether care organizations with many or only a few migrant care workers have different attitudes toward migrant care workers. The question used from the questionnaire for the dependent variable is question number six. The question is: 'Do migrant care workers with a patient-related function work in the care organization? Can you give an estimation of the number of migrant care workers in the care organization (with a patient-related function)?'. Possible answers were 'yes, namely … (number of

migrant care workers)', 'yes, but I do not know how many' and 'no, there are no migrant care workers in the care organization '. The results for this question are shown in table 1.

Table 1. Frequencies of the number of migrant workers in care organizations.

Migrant workers in care organizations	Frequencies	Percentage
Yes, namely…	57	54.3
Yes, but do not know how many	38	36.2
No migrant workers in organization	10	9.5
Total	**105**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

There are too little 'no' answers to create a 'yes-no' variable. Only the respondents who answered 'yes, namely…' and the respondents who answered 'no' will be used in the analysis. This way it is possible to take the percentage of migrant care workers into account within the analysis. A negative consequence of the decision not to use the respondents who answered 'yes, but I do not know how many' are that the N in the analysis will be smaller. The sample size for the analysis is 67. Percentages of migrants within the care organization have been calculated by using the answers the respondents gave to the question how many migrants work in the care organization and how many care givers in total work in the organization. The percentages of migrant care workers in care organizations vary from 0% to 52.50%. The mean of the variable is 8.28% with a standard deviation of 13.83%. The mean of the variable is low considering that the range is from 0% to 52.50%. In table 2 are the results for the dependent variable shown in categories. About 55% of the 67 care organizations only have between 0.01% and 5% migrant care workers in their care organization. The table shows why the mean is low, namely about 85% of the care organizations has less than 15% of migrant care workers employed.

Table 2. Frequencies of the percentage of migrant workers in care organizations.

Percentage of migrant workers in care organizations	Frequencies	Percentage
0%	10	14.9
0.01 – 5%	37	55.2
5.01 – 15%	10	14.9
15.01 – 25%	3	4.5
25.01 – 40%	2	3.0
40 – 60%	5	7.5
More than 60%	0	0
Total	**67**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

3.3.2 Filling vacancies

To test hypothesis one, about how hard it is for care organizations to get vacancies filled, question twenty from the questionnaire will be used. This question consisted of four statements about how hard it is to fill vacancies. There were five possible answers on a scale, namely 'strongly disagree', 'disagree', 'neither disagree nor agree', 'agree' and 'strongly agree'. The statements are 'enough people apply for every patient-bound vacancy', 'it is hard to fill patient-bound vacancies', 'not enough (suitable) people apply for vacancies' and 'the higher the level of the function, the harder it is to fill vacancies'.

The first statement has been recoded, because it was formulated in a different direction than the other three statements. Not recoding the statement, would lead to incorrect conclusions. To see whether the statements correlate, a correlation matrix has been run. The matrix shows that the first and fourth statement do not significantly correlate. Further, a factor analysis and a reliability analysis have been run. Those analyses show that the Cronbach's Alpha and the total explained variance are highest when the first and fourth statement are not included in one variable with the other two statements. The inter-item correlations of the first and fourth statements are under 0.35, which is another indication that those statements do not fit into one variable with the other statements. A variable will be made with the second and third statement. The total explained variance is 86.31%. The Cronbach's Alpha is 0.841.

The variable measures whether care organizations find that they have a hard time filling up vacancies. In table 3 are the frequencies of the variable shown. Four respondents did not answer the question. In the tables of the analysis the variable will be called 'filling vacancies'.

Table 3. Frequencies of the variable 'filling vacancies'.

It is hard to fill vacancies	Frequencies	Percentage
Strongly disagree	3	4.8
Disagree	16	25.4
Nor disagree, nor agree	14	22.2
Agree	23	36.5
Strongly agree	7	11.1
Total	**63**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

3.3.3 Language skills

For both hypotheses two and three, about the Dutch and foreign language skills of migrant care workers, question eleven from the questionnaire will be used. This question consists of four statements. There were five possible answers on a scale, namely from 'strongly disagree' to 'strongly agree'. The statements are 'good knowledge of the Dutch language improves communication between cooperating care givers', 'good knowledge of the Dutch language improves communication between care giver and care receiver', 'good knowledge of the Dutch language is a reason to hire someone, migrant workers are a positive addition for the care organization, because care receivers with a foreign background will appreciate it if a care giver speaks their native tongue' and 'migrant care workers' knowledge of foreign languages add to a better quality of care within the care organization '.

To get to a reliable variable here, the same steps will be taken as with the 'filling vacancies' variable. Recoding is not necessary, because all statements are in the same direction. A correlation matrix shows that the fourth statement does not significantly correlate with the first and second statement. This is logical, because the first three statement are about Dutch language skills and the fourth statement is about foreign language skills. Factor analysis shows that there are two factors, with on the first factor the first three statements and on the second factor the fourth statement. The total explained variance per factor is 60.01% for the first factor and 26.95% for the second, with a cumulated total explained variance of 86.96%. The Cronbach's Alpha for the four statements together is 0.764 and without the fourth statement it is 0.812. Likert analysis shows an inter-item correlation above 0.35 for all the statements, except for the fourth statement with the first and second statement.

Two variables will be used for these hypotheses. The first variable will consist of the first three statements and the second variable will be the fourth statement. The first variable measures

the value human resource managers ascribe to a good knowledge of the Dutch language, whether they agree or disagree that a good knowledge of the Dutch language improves communication and quality within the care organization. Results for this variable are shown in table 4. Five respondents do not have a score on this variable. In the tables of the analysis the variable will be called 'Dutch language skills'. The second variable measures the value human resource managers ascribe to knowledge of foreign languages, whether they agree or disagree that knowledge of foreign language can improve care quality in the organization. Results for this variable are shown in table 5. Five respondents do not have a score on this variable. In the tables of the analysis the variable will be called 'foreign language skills'.

Table 4. Frequencies of the variable 'Dutch language skills'.

Knowledge of Dutch language is good for organization	Frequencies	Percentage
Strongly disagree	5	8.1
Disagree	0	0.0
Nor disagree, nor agree	0	0.0
Agree	32	51.6
Strongly agree	25	40.3
Total	**62**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

Table 5. Frequencies of the variable 'foreign language skills'.

Knowledge of foreign languages is good for organization	Frequencies	Percentage
Strongly disagree	11	17.7
Disagree	16	25.8
Nor disagree, nor agree	20	32.3
Agree	8	12.9
Strongly agree	7	11.3
Total	**62**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

3.3.4 Satisfaction with migrant care workers

Hypothesis four was about dissatisfaction and hypothesis five was about satisfaction with migrant

care workers. In the questionnaire are no specific statements relating to this, because it would be too suggestive about prejudices human resource managers might have. That is why two open questions were formulated. Question seven was for the care organization that have no migrant care workers employed. The question asks why there are no migrant care workers in the care organization. Question eight was for the care organization with migrant care workers employed. The question asks whether the care organization is satisfied with the employed migrant care workers and whether they can give reasons why the organization is satisfied or dissatisfied with the migrant care workers. It is not possible to quantify the answers given to those questions. The answers will be discussed in chapter four.

3.3.5 Diploma acceptance

Whether care organizations struggle with the acceptance of foreign diplomas due to national policies is tested with hypothesis six. Question nineteen in the questionnaire consists of five statements regarding this subject. The statements are 'hiring migrant care workers is hard because of national policies', 'acceptance of foreign diplomas via national policies is an expensive process', 'acceptance of foreign diplomas via national policies is a time-consuming process', 'it is an insecure process to get foreign diplomas accepted via national policies' and 'the process of getting foreign diplomas accepted via national policies is unclear'. There were five possible answers on a scale from 'strongly disagree' to 'strongly agree'. Another answer possibility was 'does not apply', in case care organizations never tried to get foreign diplomas accepted.

Again, the same procedure as with the 'filling vacancies' and the 'language skills' variables does apply here. Recoding is not necessary, because all the statements are formulated in the same direction. The correlation matrix shows that all statements significantly correlate with each other. The factor analysis shows one strong factor with a total explained variance of 70.92%. The Cronbach's Alpha is 0.895 and will not get significantly stronger by deleting one of the statements. Also, likert analysis show that all inter-item correlations are above 0.35. These results mean that a variable can be made of the five statements. The variable measures whether care organizations do have trouble with accepting foreign diplomas. The results are shown in table 6. Sixteen respondents did not answer the question. In the tables of the analysis the variable will be called 'diploma acceptance'.

Table 6. Frequencies of the variable 'diploma acceptance'.

It is hard to get foreign diplomas accepted	Frequencies	Percentage
(Strongly) disagree	9	17.6
Nor disagree, nor agree	25	49.1
(Strongly) agree	17	33.3
Total	**51**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

3.3.6 Control variable: population density

Van Hooren (2011) found that about 29% of the care workers in convalescent or nursing homes were allochthonous workers in 2008 (SIGRA, 2008). That number shows an overrepresentation of allochthonous workers in the care sector, compared to the number of allochthonous workers in other sectors. Van Hooren (2011) suggests that population density might be of influence when it comes to the number of migrants working in a care organization. That is why population density will be taken into account within this study, as a control variable. Question two from the questionnaire will be used. The question asks for the postal code of the care organizations. Statistics Netherlands (CBS, 2011) has data about the number of people living in a postal code area. This data is linked to the dataset of this study. In the tables of the analysis the variable will be called 'population density'.

3.3.7 Descriptive variables

In the questionnaire were more questions asked than will be used to test the hypotheses. The frequencies of the answers given on those questions can be found in appendix 2. Here I will describe some of the results of the questions.

About 51.5% of the 67 care organizations provide home care, convalescent homes and nursing homes. The other half of the care organizations provide one or two of these care forms. The number of care givers working in care organizations differs a lot. About 24% of the care organizations has less than a hundred care givers employed, about 26% has between the 100 and 250 care givers employed, about 17% has between 250 and 500 care givers employed, about 12% has between 500 and 1000 care givers employed and about 21% of the care organizations has more than a thousand care givers employed. The number of care receivers within the care organizations are also divided into the same categories as used for care givers. 34.5% of the care organizations has between 100 and 250 care receivers and about 7% has between the 750 and 1000 care receivers. For the other categories, the percentages are around the 15%. Those numbers of care givers and care receivers

show that there is a good division of small and big care organizations within the dataset. The exact results are shown in table 7.

Table 7. Frequencies of the number of care givers and care receivers.

Number of care givers/receivers	Care givers		Care receivers	
	Frequencies	Percentage	Frequencies	Percentage
0 – 100	16	24.2	8	13.8
101 - 250	17	25.8	20	34.5
251 – 500	11	16.7	10	17.2
501 – 750	3	4.5	7	12.1
751 - 1000	5	7.6	4	6.9
More than 1000	14	21.2	9	15.5
Total	**66**	**100**	**58**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

57 care organizations within the dataset do have migrant care workers employed. 55 of these organizations answered questions about the level of the functions and the area of origin of the migrant care workers. The migrant workers within the care organizations are mainly employed in the lowest three levels of patient-bound functions. This is in line with previous literature on the subject (SIGRA, 2008; Van Hooren, 2011; Visser-Jansen and Knipscheer, 2004). Percentages are shown in table 8.

Further, table 8 also shows information about the area of origin from migrant workers. Migrant care workers are mainly from the areas of origin North Africa (22.1%), Middle East (19.2%), Eastern Europe (19.2%) and European countries (18.3%). These results are not surprising, since the two main allochthonous groups in the Netherlands are Moroccan (in North Africa) and Turkish (in the Middle East). However, Van Hooren (2012) mentions that allochthonous workers mainly originate from Dutch colonies or from European countries and Bloemendaal et al. (2008) mentions that mainly Surinamese women and women from Western countries work in the Dutch elderly care. Both the studies of Van Hooren (2012) and Bloemendaal et al. (2008) mention that there is an underrepresentation of Turkish and Moroccan (female) care workers. Another thing Van Hooren (2012) found is that Eastern Europeans hardly work in the care sector. The findings within this study contradict with findings of Van Hooren (2012) and Bloemendaal et al. (2008), because next to European countries, migrant care workers are mainly from North Africa, the Middle East and Eastern Europe.

Table 8. Percentages of functions and area of origin of migrant care workers.

Function	Percentage	Area of origin	Percentage
Helpende (level 2)	31.5	North Africa	22.1
Verzorgende (level 3)	28.3	Middle East	19.2
Zorghulp (level 1)	27.7	Eastern Europe	19.2
Nurse (level 4)	6.3	EU Countries	18.3
Physician (level 6)	3.1	Middle and South Africa	9.6
Nurse (level 5)	3.1	South and Eastern Asia	7.7
Total	**100**	South Africa	3.9
		Total	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

Twelve care organizations consciously aim to hire migrant care workers. Reasons for deliberate hiring are more diversity in the organization, better quality of care for care receivers with a foreign background or improved communication with care receivers with a foreign background. 28 organizations co-operate in learn- and work-programs that give people the chance to combine studying and working. Nineteen of those 28 care organizations do say that migrants participate in those programs, but most of them mention that less than 25% of the participants are migrants. And at last, 38 care organizations answered that migrants do apply for jobs with a foreign diploma. 50 care organizations answered that they will accept foreign diplomas, as long as they are generally accepted and valued within the Netherlands.

3.4 Data observations

3.4.1 Correlations

In table 9 is a correlation matrix presented of all the variables that will be included in the analysis. The correlation matrix will give an indication for the results in the analysis and can show if there are any unexpected correlations between variables. Correlations cannot say anything about causality and that is why a regression analysis has to be done.

Several significant correlations are found between variables. The most important correlations are those between the variables 'foreign language skills' and 'population density' with the dependent variable 'percentage of migrants in care organization'. The correlations cannot say

anything specific about the causality between the dependent variable and the other variables, but it can be expected that those variables will give significant results in the regression analysis.

Table 9. Correlations of the dependent, independent and control variables.

	Percentage of migrants in org.	Filling vacancies	Dutch language skills	Foreign language skills	Diploma acceptance
Percentage of migrants in org.	-				
Filling vacancies	-0.064	-			
Dutch language skills	-0.052	0.195	-		
Foreign language skills	0.317**	0.120	0.366***	-	
Diploma acceptance	-0.021	-0.011	0.251*	0.385***	-
Population density	0.274**	0.058	0.095	0.241*	0.247*

Significance: *** p<0.01; ** p<0.05; * p<0.1.
Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

Further, the 'diploma acceptance' variable correlates positively with the 'Dutch language skills' variable. This means that the more care organizations find Dutch language skills important for communication within the organization, the harder they find it to get foreign diplomas accepted. Or it is the other way around, the harder care organizations do find it to get foreign diplomas accepted, the more they value Dutch language skills. There is also a positive correlation between 'Dutch language skills' and 'foreign language skills'. Which means that care organizations that find Dutch language skills important, also find foreign language skills valuable, or the other way around. The variable 'foreign language skills' also correlates positively with 'diploma acceptance'. Which means that care organizations that value foreign language skills, find it harder to get foreign diplomas accepted. Or the other way around; care organizations that have a hard time getting foreign diplomas accepted, do value foreign language skills more. The 'population density' variable correlates positively with both the 'foreign language skills' variable and the 'diploma acceptance' variable. This means that the higher the population density is, the more foreign language skills are valued and the harder care organizations it find to get foreign diplomas accepted. Although correlations cannot say anything about causality, in this case it is unlikely that the variables 'foreign language skills' and 'diploma acceptance' influence the variable 'population density'.

3.4.2 Missing values

In section 3.3.1 is mentioned that the number of respondents who have a score on the dependent variable is 67. When doing multiple linear regression analysis the respondents with missing values on one or more variables usually will be deleted from the entire analysis (listwise deletion). One way to

minimize the missing values, is to replace the missing values with another score (e.g. mean). Replacing the missing values in this study cannot be done, because of the small sample size. Replacing missing values would too much influence the results. A way to use all the available information in the dataset is to use pairwise deletion. The pairwise deletion method uses all the available data, which means that the results in an analysis are based on different sample sizes. A consequence of the different sample size per model in the analysis is that the results might differ per model. The sample size in this study is small, which means that sample sizes per model will not change that much. In consequence, results probably will also not differ that much per model.

3.4.3 Further observations

It has been checked whether there are any extreme outliers and there are some scores which could be considered outliers. But it is found that there are no outliers that influence the results too strongly. Also, collinearity statistics have been run. There are no tolerance scores under 0.1 and no VIF scores higher than 10, which means that there is no collinearity.

3.5 Social and scientific relevance

3.5.1 Social relevance

A labor shortage of care workers is a social problem, since all citizens do have the right to receive care whenever they are in need of it. This means that elderly citizens do have the right to be taken care of when they cannot do it themselves anymore. A responsibility of the government is to create policies that make it possible for everyone to find a way to receive this care. In the Netherlands elderly care usually happens through institutionalized care or through buying care with a personal budget. The current care workers are ageing and the labor shortage in the care sector is increasing. In other Western countries migrant workers turned out to be an answer to the labour shortage in the care sector (Kilkey, Lutz and Palenga-Möllenbeck, 2010). There has been little research regarding migrant workers in the Dutch care sector. This research can give an insight to which issues are present in the Netherlands that forestall migrant care workers to start working in the elderly care sector, or that forestall care organization to hire migrant care workers. The results of this research might help policy makers to find a solution to attract migrant workers to the care sector in the Netherlands.

3.5.2 Scientific relevance

There has not yet been any specific research that investigates to what extent migrant care workers are present in the elderly care sector in the Netherlands. There are some researchers who talk about

it without giving any numbers, like Visser-Jansen and Knipscheer (2004) or The (2008). Non-scientific reports like 'Arbeid in Zorg en Welzijn' (AZW, 2011) and SIGRA (2008) give some numbers, but without any specifications or only for Amsterdam. Van Hooren (2011) discusses quite extensively the limited importance of migrant workers in the Netherlands. She uses figures from reports like SIGRA and 'Arbeid in Zorg en Welzijn' and qualitative interviews. From those figures and interviews she suggests possible explanations for the limited importance of migrant workers. Williams (2010; 2012) discusses the intersection of migration and care regimes and states that there are tensions between migration and care policies. Van Hooren (2012) finds that the Netherlands has an social democratic care regime and does not have any need for migrant care workers. Van Hooren (2012) states this without actually having numbers on migrant care workers in the Netherlands.

In short, in previous literature statements and guesses have been made about migrant or allochthonous care workers in the Netherlands. A research that scientifically tests those statements and guesses has not been done yet and that is why this study is of relevance.

3.6 Explanation of the interdisciplinary character of the research

The focus within the study is on the employment of migrant workers in elderly care organizations in the Netherlands. This topic in itself combines two research and policy fields, namely migration and care. Theories of both fields are necessary to create a better understanding of the topic. Those theories come from disciplines like sociology, psychology, business and administration sciences. Further, knowledge from the methodology and statistics field is used to come to the best possible analysis method for this study. This study is a typical interdisciplinary research, because it cannot be done without using knowledge from several disciplines.

4. Results

4.1 Introduction

In this chapter the results of the analysis will be presented. The analysis method within this study is multiple linear regression analysis. First the analysis in general will be discussed, followed by a discussion of the results per hypothesis.

4.2 Results of analyses

The results of the multiple linear regression analysis are shown in table 10. Five models have been run, in every model one extra variable is added. The first model only includes the control variable 'population density' and the second model includes the variable which had a significant correlation with the dependent variable, 'foreign language skills'. The constant represents the percentage of migrants working in a care organization when the score on all included variables is 0. The adjusted R^2 of model 5, with all variables included, is 0.127. This means that 12.7% of the variance of the model is explained for the entire population, which are all care organizations in the Netherlands.

Table 10. Multiple linear regression analysis with dependent variable 'percentage of migrant workers in care organizations'.

	Model 1	**Model 2**	**Model 3**	**Model 4**	**Model 5**
	B	**B**	**B**	**B**	**B**
Constant	0.309	-6.066	-2.080	5.226	10.225
Filling vacancies			-1.447	-1.081	-1.302
Dutch language skills				-2.521	-2.135
Foreign language skills		3.007**	3.147**	3.859**	4.542**
Diploma acceptance					-2.875
Population density	0.001**	0.001*	0.001*	0.001*	0.001*
Adjusted R^2	**0.061**	**0.113**	**0.110**	**0.124**	**0.127**
N	**67**	**62**	**61**	**61**	**51**

Dependent variable: Percentage of migrant care workers in care organization.
Significance: *** p<0.01; ** p<0.05; * p<0.1.
Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

The variables 'foreign language skills' and 'population density' do explain most of the variance of the model. This can be seen in model 2, where already 11.3% of the variance of the model is explained by those two variables. The variables 'population density' and 'foreign language skills' have in all models

a positive, significant effect on the dependent variable 'percentage of migrant workers in a care organization'.

Regression analysis may show that variables are not significant on their own, but it can be that two variable together have a positive significant influence. In the results in table 10 can be seen that there are no big differences in the adjusted R^2 when new variables are added, which indicates that there are no combinations of variables that do explain more of the variance of the model. Also, the b-coefficients and their significance stay about the same no matter which variable is added. Only the constant changes from negative to positive when more variables with negative b-coefficients are added in model 4. In the following sections the results presented in table 10 will be discussed per hypothesis.

4.2.1 Filling vacancies

In chapter two is discussed that native workers are not willing to work in the elderly care sector, because of low wages and unfavorable working conditions. The expectation formulated as hypothesis one was that the shortage of native care workers might be a reason for human resource managers to hire migrant care workers.

In model 3, where 'filling vacancies' is first added to the analysis, is the constant -2.080 and the b-coefficient is -1.447. When the variables 'Dutch language skills' and 'diploma acceptance' are added to the analysis, the constant turns positive to 10.225 in model 5. The b-coefficient of 'filling vacancies' changes a bit per model, but stays negative. This means that with every step the score on the constant declines. In other words, the more people agree that it is hard to fill patient-bound vacancies, the lower the percentage of migrant care workers in care organizations. This is in line with hypothesis one. In the hypothesis is expected that care organization who find it not that hard to fill vacancies, already employ migrant care workers to lessen the shortage of care workers and thus have a higher percentage of migrant care workers.

However, the b-coefficient for 'filling vacancies' is not significant in all three models. Hypothesis one cannot be confirmed. As described above, the results are in the expected direction, but no significance means that in this study there is no difference between care organizations with a low percentage or a high percentage of migrant care workers considering the trouble they have with filling vacancies.

4.2.2 Dutch language skills

Hypothesis two is about Dutch language skills of migrant care workers. Care organizations might expect of migrant care workers that their Dutch language skills are good, because they are necessary for good communication on the work floor. The expectation of hypothesis two was that the more care organizations value Dutch language skills, the lower the percentage of migrant care workers in

the care organization will be.

In the analysis the 'Dutch language skills' variable is added in model 4. The constant in model 4 is 5.226 and the b-coefficient is -2.521. For model 5 the constant is 10.225 and the b-coefficient for 'Dutch language skills' is -2.135. This means that the more care organizations agree with that good Dutch language skills are necessary for good communication, the lower the percentage of migrant care workers is in care organizations. This is in line with hypothesis two. However, in both models is the b-coefficient for 'Dutch language skills' not significant. Hypothesis two cannot be confirmed. Thus, the results are in the expected direction, but in this study is no significant difference between care organizations with a low percentage or a high percentage of migrant care workers if it comes to the value they ascribe to Dutch language skills.

4.2.3 Foreign language skills

Hypothesis three is about the value foreign language skills of migrant care workers might have for the care organization. Foreign language skills of migrant care workers might be a reason for care organizations to hire migrant workers. It is expected that the more care organizations value foreign language skills, the higher the percentage of migrant care workers in the care organization will be.

In model 2 is the 'foreign language skills' variable added. The constant is -6.066 and the b-coefficient is 3.007. In the following three models the constant changes to a positive score of 10.225 in model 5. The b-coefficient of the 'foreign language skills' variable stays positive and is 4.542 in model 5. This means that the more foreign language skills are valued in care organizations, the higher the percentage of migrant care workers in those care organizations. In all four models is the b-coefficient of 'foreign language skills' significant, which confirms hypothesis three. Care organization that value foreign language skills have a higher percentage of migrant care workers in the organization than care organizations that do not value foreign language skills.

4.2.4 Diploma acceptance

The expectation of hypothesis six is that the harder it is for care organizations to get foreign diplomas accepted, the lower the percentage of migrant care workers in the organization will be. Model 5, where the 'diploma acceptance' variable is added, has a constant of 10.225 and the b-coefficient for 'diploma acceptance' is -2.875. This means that the harder care organizations find it to get foreign diplomas accepted, the lower the percentage of migrant care workers in those organizations. This is in line with hypothesis six. But the b-coefficient for 'diploma acceptance' is not significant. The results are in the expected direction, but in this study is no significant difference between care organizations with a low percentage or a high percentage of migrant care workers if it comes to how hard they find it to get foreign diplomas accepted.

4.2.5 Control variable: Population density

The first model was run with only the dependent variable and the control variable 'population density' in it. The correlation analysis in chapter three already showed a significant correlation between the control and dependent variable. In all five models of the regression analysis is the b-coefficient for 'population density' 0.001. The b-coefficient is in all models (weakly) significant. This means that the higher the population density, the higher the percentage of migrant care workers is in a care organization. This result shows that it is important to take population density into account when analyses on migrant workers in care organizations are done.

4.2.6 Satisfaction with migrant care workers

Hypotheses four and five are about the satisfaction or dissatisfaction of care organization with migrant care workers. The expectation formulated as hypothesis four was that the more care organizations are dissatisfied with migrant care workers, the lower the percentage of migrant care workers will be in the care organizations. The expectation formulated as hypothesis five was that the more care organizations are satisfied with migrant care workers, the higher the percentage of care workers will be in the care organizations. The two questions that test the hypotheses are about the reason why no migrant care workers are hired at all in some organizations and about whether care organizations are satisfied with migrant care workers within the care organization. It was not possible to quantify the answers on those questions and that is why there cannot be said anything on the confirmation of hypotheses four and five. However, I will discuss the answers given on the questions by the 105 care organizations in the dataset. A lot of respondents gave several reasons for satisfaction or dissatisfaction with migrant care workers, that is why the numbers given in the following paragraphs are in total higher than the sample size. Respondents could give answers that both fit in the satisfaction and the dissatisfaction category.

Answers that were in line with hypothesis four were given. There are several reasons why care organizations are not satisfied with or do not hire migrant care workers. One reason is that migrant workers struggle with the Dutch language. About seventeen times language problems were given as a reason. A second reason is cultural differences between the care receiver and care giver or between colleagues, this was mentioned about six times. A third reason, mentioned seven times, is that migrant care workers can have a different work ethic than native care workers. An example for this reason is that migrant care workers call in sick more often than native care workers. Especially the first reason is mentioned as a reason for human resource manager to not hire or to be dissatisfied with migrant care workers.

Answers in line with hypothesis five, about the satisfaction with migrant care workers, were also given. Respondents mentioned about fifteen times that migrant care workers are motivated,

involved employees. Another reason is that the employment of migrant care workers creates diversity (mentioned three times) and connects to care receivers with a foreign background, which was mentioned four times. Also, cultural differences are mentioned as a positive addition to the care organization.

The answers given on the questions are in line with both hypotheses. Next to the specific reasons for being satisfied or dissatisfied with migrant care workers, about 47 respondents answered that they are generally satisfied with the migrant care workers. Also, about ten of the respondents answer that there is no difference with native care workers.

5. Conclusion

5.1 Introduction

The goal in this chapter is to answer the research question and sub-questions. There will be a discussion of the link between the results presented in chapter four and the theories discussed in chapter two. What this study means for the Dutch elderly care, for theories concerning care regimes and migrant care workers and for the Netherlands compared to other countries will also be discussed. In section 5.3 will be a discussion of problems this study had and recommendations for future research will be given.

5.2 Conclusion

The research question formulated in chapter two of this study is: *To what extent are migrant care workers present in the elderly care sector in the Netherlands and why do care organizations hire or not hire them?* Sub-questions were about descriptive characteristics of the migrant care workers in the Netherlands and about reasons why care organizations would hire or not hire migrants. To answer these questions hypotheses were formulated. The hypotheses were about how care organizations deal with filling vacancies, the acceptance of foreign diplomas, how they value foreign and Dutch language skills of migrant workers and about the satisfaction of care organizations with migrant care workers.

First, the question 'to what extent are migrant care workers present in the elderly care sector in the Netherlands?' can be answered by giving some descriptions. 95 of the 105 care organizations that filled out the questionnaire that was set up for this study answered that they do have migrant care workers employed in the care organization. However, the part of migrant care workers of the total care workers in organizations is generally low. 37 of the 57 care organizations that gave an answer about the number of migrant care workers in their organization, have only between 0.01% to 5% migrant care workers employed. So, although many care organizations confirm that migrant care workers are present in the elderly care sector, they are only present for a very small part of the total care workers in the Dutch elderly care sector.

Further is found that migrant care workers mainly work in the lowest three levels of patient-related functions. This is in line with previous findings of SIGRA (2008), Van Hooren (2011) and Visser-Jansen and Knipscheer (2004). Another striking finding is in contrast with previous literature. About 80% of the migrant care workers in the elderly care sector in the Netherlands are either from

North Africa, Middle East, Eastern Europe or European countries. Bloemendaal et al. (2008) found that mainly Surinamese women and women from Western countries work in the Dutch elderly care. and that there is an underrepresentation of Turkish and Moroccan women in the health care sector. Van Hooren (2012) does not have numbers or percentages, but mentions that care workers hardly come from North Africa, the Middle East or Eastern Europe. Hoffer (2005) mentions that one of the reasons that Turkish and Moroccan elderly do not want to live in convalescent or nursing homes, is because there are no Turkish or Moroccan care givers. Although migrants may be underrepresented in the care sector, like Bloemendaal et al. (2008) concluded for migrant women, my findings do suggest that the migrants working in the elderly care sector are mainly from North Africa, the Middle East and Eastern Europe. That is in contrast with the statements of previous literature.

The second part of the research question 'why do care organizations hire or not hire migrant workers?' can be answered by discussing the results presented in chapter four. The main finding was that organizations who value the foreign language skills of migrant care workers, do have a higher percentage of migrant care workers employed in the organization. This finding is in line with the theory of Cangiano et al. (2009) that care organizations value foreign language skills of migrant care workers, because it improves the care for care receivers with a foreign background.

Another main finding was that the population density is of influence when it comes to the percentage of migrant care workers in a care organization. The higher the population density, the higher the percentage of migrant care workers in a care organization. This is as expected, because relatively more migrants live in areas with high population density than in areas with low population density.

What do the results of this study mean for the elderly care sector in the Netherlands? On a national basis, this study has shown that migrants are already a small part of the elderly care workforce. In comparison with countries where the employment of migrants in the care sector has shown to be a solution for the labor shortage, is the number of migrant care workers in the Netherlands still small. It cannot be said for the Netherlands that the employment of migrant care workers is used as a solution to reduce the labor shortage. To what extent the employment of migrant workers can be a solution for the Dutch labor shortage in the care sector depends on several factors.

First, the employment of migrant workers has to match the social democratic care regime which is present in the Netherlands. In other regimes, the liberal and familialistic, are migrants employed via the private sector or directly via family (Van Hooren, 2012). In the Netherlands direct employment via family does not, or scarcely, exist. There is a great reliance on the public care system. A private care sector is present in the Netherlands, but the private and public care sector use the same demands for hiring care workers. This is unlike other care regimes, where the private care

sector has bad working conditions (Van Hooren, 2012). To work in the Dutch elderly care sector, a diploma obtained or valued in the Netherlands is necessary. This makes it harder to organize a swift drop in labor shortage by employing migrant care workers, because they will need education first or they need to wait until their foreign diploma is evaluated. There is no significant confirmation, but findings in this study do suggest that the acceptance of foreign care diplomas in the Netherlands is hard. Those findings in this study are in line with Williams' (2012) theory about the tensions between national migration and care policies. Even in a social democratic care regime as present in the Netherlands, migrant workers can be a solution to the labor shortage, if migration policies (i.e. no direct acceptance of foreign diplomas) would be adjusted to it. For example, learn- and work-programs aimed at migrants might help.

Second, the Dutch population is ageing and as described by Eggink et al. (2010) that means that the number of users of the care sector is growing by 1.2% per year. That the population is ageing, also means that the allochthonous population in the Netherlands is ageing. That group will start using the public elderly care system more and more and might cause a need for change in policies for care organizations (Hoffer, 2005). This will mainly be in areas with higher population density, cities. To answer to this change of characteristics of the clients in care organizations, care organizations might want to hire more migrant workers. Positive correlations found in this study between population density and the value care organizations ascribe to foreign language skills support the theory that especially care organizations in cities might want to hire more migrant workers for their migrant care receivers. Migrants live relatively more in cities than in rural areas, which might mean that there are more migrant care receivers in cities. Which leads to a greater need of migrant care workers with foreign language skills in cities to help the migrant care receivers.

The care system and the migration and care policies in the Netherlands are not ideal for the employment of migrant care workers (Williams, 2012; Van Hooren, 2012), but this study has shown that it is possible and that the skills of migrant care workers can have value for the Dutch elderly care sector. This conclusion has both scientific and societal consequences.

The main scientific consequences of the conclusion that migrant care workers can be of value for the Dutch elderly care system, is that more theories on migrant care workers are needed. Those theories can help to answer questions like what the role of migrant care workers can be in social democratic care regimes. Or which specific issues arise as a consequence of the tension between migration and care policies.

One societal consequence of the conclusion is that national policy makers should think about possibilities for migrant care workers and care organizations to a smoother process of employment. Care organizations should think about specific problems they have experienced with migrant care

workers and if they can solve it. For example, care organizations may pay for language courses for migrant workers or set up learn and work programs for migrant care workers. They also may find ways to use the cultural differences instead of seeing them as a problem. Another societal consequence is that the elderly care will need and get a more diverse character, like the Dutch society. At this moment most care organizations have mainly native care receivers and native care givers.

5.3 Discussion

5.3.1 Problems

Several problems arose during this research. This research is part of an EU-project about migrant care workers in Austria, the Netherlands and the United Kingdom. The first problem was the terms used in Dutch research for persons with a foreign background. The term that is most used in the Netherlands is 'allochthonous', which includes persons who are born in a foreign country and persons of whom one or both parents are born in a foreign country. This definition is generally used in the Netherlands, with the consequence that it is also used in Dutch scientific research. The EU-project is about migrants, which only includes persons who are born in a foreign country and not persons of whom one or both parents are born in a foreign country. There are two consequences related to using the term 'migrant' in Dutch research instead of the term 'allochthonous'. The first consequence is that it is hard to find literature that connects to this research, especially when it comes down to numbers concerning migrants or allochthonous workers in the care sector. The second consequence is that the respondents who filled out the questionnaire confused migrants and allochthonous workers. If that happened, the percentages of migrant care workers in care organizations might be too high. However, it was clearly indicated in the questionnaire that the questions were about migrant workers.

The second problem in this study had to do with the prohibition for organizations to keep information on the ethnic background of employees. This prohibition was part of the reason why this study had to be done, to get numbers on migrant workers in the elderly care sector. However, a consequence of the prohibition is, that it is harder to get enough information for an adequate analysis. The prohibition makes it harder for organizations to give an estimate. Some organizations could not or would not give an estimate. The prohibition is the reason why only 57 of the 95 organizations with migrant workers in the organization gave an estimate.

The second problem leads to the third problem, namely the small sample size in this research. A consequence of a small sample size is that the chances of getting significant results are

smaller. A larger sample size might have led to more significant results.

A last problem is related to having a research topic about migrants. When formulating questions for a questionnaire about migrants, the risk is quite big that questions are suggestive. The questionnaire that was used for this study was reviewed by several persons and revised several times to prevent the risk of being suggestive.

5.3.2 Recommendations

The main issue for research on migrant care workers in the Netherlands is the fact that care organizations are not allowed to keep background information on their employees. A recommendation for future research is to take a long time for the data collection and try to collect the data in several ways. For example, not only interview one human resource manager in an organization, but also team leaders and care employees. This would lead to more diverse and reliable data.

Further, to continue on Williams' (2012) theory that migration and care policies might conflict with each other, a policy analysis could be useful. Conflicting policies would become noticed and the findings would contribute to theory and policy development. If this would be done on an international basis, it could also contribute to the development of care regime typologies.

Another recommendation for future research is that for the Netherlands, it might be useful to do a comparing research on the differences between allochtonous people and migrants. Do these two groups differ that much when it comes to their participation and functioning in the Dutch care sector? It might be that there are no big differences between the groups, which would mean that the consequences of the confusion of terms by respondents and researchers are no issue for other research.

6. Bibliography

Anderson, B. (2001). Why madam has so many bathrobes: Demand for migrant workers in the EU. *Tijdschrift voor economische en sociale geografie, 92*(1), 18-26.

AZW. (2011). Arbeid in Zorg en Welzijn 2010. Stand van zaken en vooruitblik voor de sector Zorg en de sector Welzijn en Maatschappelijke Dienstverlening, Jeugdzorg en Kinderopvang. Zoetermeer: Onderzoeksprogramma Arbeidsmarkt Zorg en Welzijn.

Bettio, F. & Plantenga, J. (2004). Comparing care regimes in Europe. *Feminist economics,10*(1), 85-113.

Bloemendaal, I., Kroon, S., de & Velde, F., van der. (2008). Allochtone vrouwen in de zorg. Motivaties, preferenties en belemmeringen voor het werken in de zorg bij Turkse en Marokkaanse meisjes en vrouwen. Raad voor Werk en in komen. Prismant.

Cangiano, A., Shutes, I., Spencer, S. & Leeson, G. (2009). *Migrant care workers in ageing societies: Research findings in the United Kingdom.* Oxford: Centre on migration, policy and society, University of Oxford.

CBS, Centraal Bureau voor de Statistiek (2011, October 21). Bevolking per postcode. Retrieved from http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=81310NED&D1=0&D2=a&HDR=T&STB=G1&VW=T.

CBS, Centraal Bureau voor de Statistiek (2012, October 18). Bevolkingscijfers. Retrieved from http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=37296ned&D1=19-21&D2=0,10,20,30,40,50,(l-1)-l&VW=T.

CBS, Centraal Bureau voor de Statistiek (2012, October 18). Zorginstellingen. Retrieved from http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=81732ned&D1=0&D2=6,9&D3=3-4&HDR=G2,G1&STB=T&VW=T.

CORDIS (2011, October 18). Caring labour in a migrating world. Retrieved from http://cordis.europa.eu/search/index.cfm?fuseaction=proj.document&PJ_RCN=12065468

DUO, Dienst Uitvoering Onderwijs. (2012, October 20). The evaluation of a foreign diploma in the Netherlands. Retrieved from http://www.ib-groep.nl/international_visitors/Diploma_assessment/Coming_to_the_Netherlands/s40_diploma_evaluation.asp

Da Roit, B. (2010). *Strategies of care. Changing elderly care in Italy and the Netherlands.* Amsterdam: Amsterdam University Press.

Eggink, E., Oudijk, D. & Woittiez, I. (2010). *Zorgen voor zorg. Ramingen van de vraag naar personeel in de verpleging en verzorging tot 2030.* Den Haag: Sociaal en Cultureel Planbureau.

Esping-Andersen, G. (1999). *Social foundations of postindustrial economies.* Oxford: Oxford University Press.

Hoffer, C. (2005). Allochtone ouderen: de onverwachte oude dag in Nederland. *Onzichtbaar – onmisbaar. Ouderen in Rotterdam – Essays, Cahier 04*, 7-30.

Jennissen, R. (2007). Causality chains in the international migration systems approach. *Population research and policy review, 26*, 411-436.

Kilkey, M., Lutz, H. & Palenga-Möllenbeck, E. (2010). Introduction: Domestic and care work at the intersection of welfare, gender and migration regimes: Some European experiences. *Social policy & society, 9*(3), 379-384.

Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A., & Taylor, J. E. (1993). Theories of international migration: A review and appraisal. *Population and Development Review, 19*(3), 431–466.

Rijksoverheid (n.d., October 18). Wat is de VPZ? Retrieved from http://www.rijksoverheid.nl/onderwerpen/persoonsgebonden-budget-pgb/vraag-en-antwoord/wat-is-de-vergoedingsregeling-persoonlijke-zorg-vpz.html.

Sadiraj, K., Oudijk, D., Kempen, H., van & Stevens, J. (2011). *De opmars van het pgb. De ontwikkeling van het persoonsgebonden budget in nationaal en internationaal perspectief.* Den Haag: Sociaal en Cultureel Planbureau.

SIGRA (2008). Rapportage: Allochtone medewerkers in de zorg. Een inventarisatie onder gezondheidszorginstelling in Amsterdam en omstreken over 2006. Retrieved from: http://www.werkindezorg.nl/scrivo/asset.php?id=116849

Simonazzi, A. (2009). Care regimes and national employment models. *Cambridge journal of economics, 33*, 211-232.

Spencer, S., Martin, S., Bourgeault, I.L. & O'Shea, E. (2010). The role of migrant care workers in ageing societies: Report on research findings in the United Kingdom, Ireland, Canada and the United States. Geneva, Switzerland: International organization for migration.

Taylor-Gooby, P. (ed.) (2004). *New risks, new welfare. The transformation of the European welfare state.* Oxford: Oxford University Press.

The, B.A.M. (2008). *In death's waiting room: living and dying with dementia in a multicultural society.* Amsterdam: Amsterdam University Press.

Ungerson, C. (2004). Whose empowerment and independence? A cross-national perspective on 'cash for care' schemes. *Ageing and Society, 24*, 189-212.

Van Hooren, F.J. (2011). Caring migrants in European welfare regimes: The policies and practice of migrant labour filling the gaps in social care. Retrieved from: http://cadmus.eui.eu/bitstream/handle/1814/17735/2011_VanHooren.pdf?sequence=2

Van Hooren, F.J. (2012). Varieties of migrant care work: Comparing patterns of migrant labor in social care. *Journal of European Social Policy, 22*(2), 133-147.

Vernooij-Dasssen, M.J., Faber, M.J., Olde Rikkert, M.G., Koopmans, R.T., Achterberg, T., van, Braat, D.D., Raas, G.P. & Wollersheim, H. (2009). Dementia care and labour market: The role of job satisfaction. *Aging & Mental Health, 13*(3), 383-390.

Visser-Jansen, G. & Knipscheer, C.P.M. (2004). Eurofamcare: National background report for the Netherlands. Retrieved from http://www.uke.de/extern/eurofamcare/.

Wet arbeid vreemdelingen (n.d., October 18). Retrieved from http://www.wetarbeidvreemdelingen.nl/.

Williams, F. (2010). Migration and care: Themes, concepts and challenges. *Social policy & society, 9*(3), 385-396.

Williams, F. (2012). Converging variations in migrant care work in Europe. *Journal of European Social Policy, 22*(4), 363-376.

Zanoni, P. & Janssens, M. (2004). Deconstructing difference: The rhetoric of human resource managers' diversity discourses. *Organization studies, 25*(1), 55-74.

7. **Appendices**

Appendix 1: Questionnaire

Migrantenwerkers in de ouderenzorg

Welkom,

Voor mijn masterthesis doe ik een onderzoek naar migrantenwerkers in de ouderenzorg in Nederland en de motivatie van zorgorganisaties om migranten aan te nemen. Dit onderzoek is een onderdeel van een EU-project, genaamd 'Caring Labour in a Migrating World'. Het doel van het EU-project is om te analyseren wat de positie is van migranten die werken in de ouderenzorg in Oostenrijk, Nederland en het Verenigd Koninkrijk

Deze vragenlijst is bedoeld voor managers van personeelsafdelingen van verpleeg- en verzorgingshuizen en thuiszorgorganisaties.
Werkt u binnen uw zorgorganisatie niet op de personeelsafdeling, maar wilt u mij wel helpen? Zou u deze enquête dan alstublieft door willen sturen naar een manager van de personeelsafdeling?

Het invullen van de vragenlijst duurt ongeveer 10 à 15 minuten en is volledig anoniem.

Start

www.thesistools.com

Migrantenwerkers in de ouderenzorg

1.

Wat is uw functie binnen de zorgorganisatie?*

PDFmyURL.com

2.

Wat is de postcode van de (hoofdvestiging van de) zorgorganisatie? Het gaat alleen om de cijfers van de postcode.*

3.

Wat voor zorg biedt uw zorgorganisatie? Er zijn meerdere antwoorden mogelijk.

- ☐ Extramurale zorg: thuiszorg
- ☐ Intramurale zorg: Verpleeghuis
- ☐ Intramurale zorg: Verzorgingshuis
- ☐ Anders

Volgende

www.thesistools.com

4.

Hoeveel werknemers met een patiënt- of bewonergebonden functie werken er binnen de zorgorganisatie?*

- ○ 0 - 100
- ○ 101 - 250
- ○ 251 - 500
- ○ 501 - 750
- ○ 751 - 1000
- ○ Meer dan 1000

PDFmyURL.com

◯Weet ik niet

5.

Aan hoeveel zorgvragers die ouder zijn dan 65 jaar biedt de zorgorganisatie zorg? Het gaat hier om zorgvragers binnen de sector Verpleging, Verzorging en Thuiszorg.*

◯0 - 100
◯101 - 250
◯251 - 500
◯501 - 750
◯751 - 1000
◯Meer dan 1000
◯Weet ik niet

6.

Bij de inleiding van deze vragenlijst is genoemd dat het een onderzoek is naar migrantenwerkers in de ouderenzorg. Migrantenwerkers zijn werknemers die niet in Nederland geboren zijn en die op een bepaald punt in hun leven gemigreerd zijn naar Nederland.
Werken er migrantenwerkers met een patiënt- of bewonergebonden functie bij de zorgorganisatie? Kunt u een schatting geven van het aantal migrantenwerkers met een patiënt- of bewonergebonden functie in de zorgorganisatie?*

◯Ja, namelijk ☐
◯Ja, maar ik weet niet hoeveel migrantenwerkers binnen de zorgorganisatie werken.
◯Nee, er werken geen migrantenwerkers binnen de zorgorganisatie.

Volgende

7.

Kunt u uitleggen waarom er geen migrantenwerkers bij uw zorgorganisatie in dienst zijn?*

Volgende

8.

Bent u over het algemeen tevreden over de migrantenwerkers binnen uw organisatie? Waarom wel of niet?*

9.

In welke functies zijn de migrantenwerkers met een patiënt- of bewonergebonden functie vooral werkzaam? Kiest u voor de drie functies waarin de meeste migrantenwerkers werken.

☐Zorghulp
☐Helpende
☐Verzorgende
☐Verpleegkundige (MBO)

☐Verpleegkundige (HBO)
☐Arts
☐Anders, namelijk

10.

Kunt u aangeven wat het meest voorkomende herkomstland of -gebied is van de migrantenwerkers die bij de zorgorganisatie in dienst zijn? Kiest u voor de drie meest voorkomende herkomstlanden of -gebieden.

☐Zuid-Afrika
☐Oost-Europa
☐Noord-Afrika (o.a. Marokko)
☐Midden- en Zuid-Afrika
☐Midden-Oosten (o.a. Irak, Iran, Afghanistan, Turkije)
☐EU-landen
☐Zuid- en Oost-Azië (o.a. China, Japan, India, Thailand, Filipijnen)
☐Anders, namelijk

Volgende

11.

Nu volgen een aantal stellingen over de beheersing van de Nederlandse taal van de migrantenwerkers binnen de sector Verpleging, Verzorging en Thuiszorg. Het gaat hierbij niet om uw persoonlijke mening, maar om de visie die de zorgorganisatie betreffende dit onderwerp heeft. U kunt antwoorden van helemaal mee oneens tot en met helemaal mee eens.

	Helemaal mee oneens				Helemaal mee eens
Een goede kennis van de Nederlandse taal verbetert de communicatie tussen de samenwerkende verzorgers en verplegers.	○	○	○	○	○
Een goede kennis van de Nederlandse taal verbetert de communicatie tussen de verzorgende en de patiënt.	○	○	○	○	○
Goede beheersing van de Nederlandse taal is een reden om iemand aan te nemen. Migrantenwerkers zijn een positieve toevoeging voor de zorgorganisatie, omdat patiënten van buitenlandse afkomst het waarderen als een verzorger hun moedertaal spreekt.	○	○	○	○	○
De kennis van buitenlandse talen van migrantenwerkers dragen bij aan een betere zorgkwaliteit van de zorgorganisatie.	○	○	○	○	○

Volgende

12.

Wordt er binnen de zorgorganisatie wel eens bewust gekozen voor het aannemen van migranten?
Met bewust kiezen voor het aannemen van migranten wordt bedoeld dat de organisatie migranten aanneemt, omdat ze betreffende bepaalde kenmerken of vaardigheden afwijken van het andere personeel. Bijvoorbeeld omdat ze een andere religie hebben.*

○Ja
○Nee

Volgende

13.

U gaf aan dat er wel eens bewust gekozen wordt voor het aannemen van migranten. Kunt u aangeven wat de voornaamste reden achter deze keuze is?*

- ◯Diversiteit binnen de organisatie vergroten.
- ◯Kwalitatief betere zorg voor patiënten met een buitenlandse achtergrond.
- ◯Betere communicatie met patiënten.
- ◯Anders; [ ]

Volgende

Er bestaan re-integratie- en scholingstrajecten die ervoor zorgen dat migranten bij zorgorganisaties aan het werk kunnen komen. Dit soort projecten combineren leren en werken en kunnen voor deelnemers zorgen dat ze doorstromen in een vaste baan binnen de zorgorganisatie. Bijvoorbeeld gemeentes of overheidsinstanties werken samen met de zorgorganisaties om dit soort trajecten mogelijk te maken.

14.

Werkt uw zorgorganisatie mee aan zulke trajecten?*

- ◯Ja
- ◯Nee

Volgende

15.

Doen er migranten mee aan de trajecten waaraan de zorgorganisatie meewerkt?*

- ◯Ja
- ◯Nee

Volgende

16.

Maken migrantenwerkers een groot deel uit van de deelnemers van het traject waaraan de zorgorganisatie meewerkt?*

- ◯Ja, (bijna) alle deelnemers zijn migranten
- ◯Ja, ongeveer driekwart van de deelnemers is migrant
- ◯Redelijk, ongeveer de helft van de deelnemers is migrant
- ◯Nee, ongeveer een kwart van de deelnemers is migrant
- ◯Nee, (bijna) geen
- ◯Weet ik niet

Volgende

17.

Solliciteren er migranten bij uw zorgorganisatie met buitenlandse diploma's?*

- ◯Ja
- ◯Nee

18.

Accepteert de zorgorganisatie buitenlandse diploma's?*

- ◯Ja, alle diploma's worden geaccepteerd.
- ◯Ja, maar alleen diploma's van binnen de EU.
- ◯Ja, maar alleen diploma's die algemeen in Nederland worden geaccepteerd.
- ◯Ja, maar anders... [ ]
- ◯Nee
- ◯Weet ik niet

Volgende

19.

Nu volgen er nog enkele stellingen over de diploma's van migrantenwerkers. U kunt antwoorden van helemaal mee oneens tot en met helemaal mee eens.

	Helemaal mee oneens				Helemaal mee eens	n.v.t.
Het aannemen van migrantenwerkers is moeilijk door overheidsregelingen.	○	○	○	○	○	□
Het is een duur proces om via overheidsregelingen buitenlandse diploma's geaccepteerd te krijgen.	○	○	○	○	○	□
Het kost veel tijd om via overheidsregelingen buitenlandse diploma's geaccepteerd te krijgen.	○	○	○	○	○	□
Het proces om via overheidsregelingen buitenlandse diploma's geaccepteerd te krijgen is onzeker.	○	○	○	○	○	□
Het proces om via overheidsregelingen buitenlandse diploma's geaccepteerd te krijgen is onduidelijk.	○	○	○	○	○	□

Volgende

20.

De volgende stellingen gaan over de vacatures binnen de zorgorganisatie. U kunt antwoorden van helemaal mee oneens tot en met helemaal mee eens.

	Helemaal mee oneens				Helemaal mee eens
Voor elke vacature die openstaat met een patiënt- of bewonergebonden functie, solliciteren er voldoende mensen.	○	○	○	○	○

Het is moeilijk om openstaande vacatures met een patiënt- of bewonergebonden functie op te vullen.	○	○	○	○	○
Er solliciteren te weinig (geschikte) kandidaten voor openstaande vacatures.	○	○	○	○	○
Naarmate het niveau van de functie oploopt, is het moeilijker om de vacatures op te vullen.	○	○	○	○	○

Volgende

21.

Overweegt u in de nabije toekomst (meer) migrantenwerkers aan te nemen? Waarom wel of niet?*

22.

Is er sprake van actieve werving van migrantenwerkers binnen uw organisatie? Zo ja, op welke manier vindt die werving plaats?*

23.

Bedankt voor de deelname aan deze enquête.
Hieronder kunt u eventuele vragen of opmerkingen kwijt.

Verstuur

Hartelijk bedankt voor het invullen van de enquête!

Appendix 2: Descriptives and frequencies

In this appendix descriptive characteristics and frequencies of variables from the questionnaire will be presented. The variables are not used in the analysis of this study, but they do contribute to expanding the knowledge about migrant care workers in the Netherlands.

1. Type of care organizations

In the questionnaire was asked what sort of care organization the respondent worked for. They could choose home care organization, convalescent homes, nursing homes or a different type of care organization. The respondent could give multiple answers. In table 11 the answers are shown without the option 'different type of care organization'. This is done, because there was only one respondent who only chose that answer. That respondent has not been included in table 11. The other respondents who chose for the other answers plus the 'different type of care organization' answer, mainly mentioned that the different type of care offered was either a type of care that had nothing to do with elderly care, or it was extra care next to home care or care in a nursing or care home.

Table 11. Frequencies of types of care organizations.

Type of care organization	Frequencies	Percentage
Home care	8	12.1
Convalescent home	6	9.1
Nursing home	4	6.1
Convalescent and nursing home	5	7.6
Home care and convalescent home	8	12.1
Home care and nursing home	1	1.5
Home care, convalescent and nursing home	34	51.5
Total	**66**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

2. Care givers and care receivers

In table 12 are the results of two questions shown. The first question is how many employees, with a patient-related function, are working for the care organization. The possible answers were specified in categories. One respondent answered that he/she did not know how many employees were working for the care organization, this respondent has not been included in table 12.

The second question asks how many care receivers, older than 65 years old, receive care from the care organization. The possible answers were specified in categories, the same as the previous question. Nine respondents answered that they did not know how many care receivers the care organization offers care to. Results are shown in table 12.

Table 12. Frequencies of care givers and care receivers in care organizations.

Number of care givers/receivers	Care givers		Care receivers	
	Frequencies	Percentage	Frequencies	Percentage
0 – 100	16	24.2	8	13.8
101 - 250	17	25.8	20	34.5
251 – 500	11	16.7	10	17.2
501 – 750	3	4.5	7	12.1
751 - 1000	5	7.6	4	6.9
More than 1000	14	21.2	9	15.5
Total	**66**	**100**	**58**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

3. Levels of functions of migrant care workers

In the questionnaire was also asked if the respondents could give a top three of the levels of functions of migrant care workers. They could choose between six functions. Those functions are based on the schooling levels for care jobs in the Netherlands. The first four functions are on different levels within 'middle-level applied education' (Middelbaar Beroeps Onderwijs, MBO), which is vocational education. The first function is 'zorghulp', which can be done after finishing level one of vocational education. Tasks done by the 'zorghulp' are social support, household chores and other small tasks that the care receiver asks to be done. The second function is 'helpende' and can be done after finishing level two of vocational education. A 'helpende' has about the same tasks as a 'zorghulp', only a 'helpende' is also allowed to help with personal care like getting dressed. The third function is 'verzorgende' and can be done after finishing level three of vocational education. A 'verzorgende' helps mainly with the personal care of the care receiver, with tasks like showering and getting dressed. Other tasks are social support and household chores. The fourth function is nurse, which is the fourth and highest level of vocational education. A nurse does medical tasks, like giving medication to care receivers. The nurse also helps with the personal care of the care receivers. The fifth function is also nurse, only on a higher education level. A nurse with this level of education has about the same function as a level four nurse, but also has responsibilities for the treatment plan of

care receivers and for coordinating activities within a department. The sixth function is (geriatric) physician. A geriatric physician is the main responsible person for the treatment of the elderly care receiver.

In table 13 is a top six shown of how often the respondents chose for a function. Twelve respondents did not answer this question. 55 respondents did answer the question. The total is 127 answers, because respondents could choose more than one answer. Next to the six functions was an extra answer option, namely 'a different function'. Fifteen times this option was chosen and respondents mainly mentioned that the different function was one of general and technical services, extra support, maintenance, or kitchen staff. Table 13 shows that migrant care workers mainly are employed in the three lowest levels of elderly care functions.

Table 13. Frequencies of functions of migrant care workers.

Functions	Frequencies	Percentage
Helpende (level 2)	40	31.5
Verzorgende (level 3)	36	28.3
Zorghulp (level 1)	35	27.7
Nurse (level 4)	8	6.3
Physician (level 6)	4	3.1
Nurse (level 5)	4	3.1
Total	**127**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

4. Area of origin

In the questionnaire is asked for a top three of the areas of origin from the migrant care workers. In table 14 the results are shown. The seven answer options are North Africa (including Morocco), Middle East (including Iraq, Iran, Afghanistan and Turkey), Eastern Europe, EU countries, Middle and South Africa, South and Eastern Asia (including China, Japan, India, Thailand and Philippines) and South Africa. 55 respondents answered this question and twelve did not. The respondents could choose for more than one option. Another option was to choose for 'a different country or area' and twelve respondents did this. They did not specify which different countries or areas of origin. The results in table 14 show that most migrant care workers are from North Africa or Middle East. This probably has to do with the countries Morocco and Turkey within these areas. Most migrants and allochthonous people in the Netherlands are from those two countries.

Table 14. Frequencies of the areas of origin of migrant care workers.

Areas of origin	Frequencies	Percentage
North Africa	23	22.1
Middle East	20	19.2
Eastern Europe	20	19.2
EU countries	19	18.3
Middle and South Africa	10	9.6
South and Eastern Asia	8	7.7
South Africa	4	3.9
Total	**104**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

5. The conscious hiring of migrant care workers by care organizations

Respondents were asked if the care organization sometimes consciously hires migrant care workers, because of certain characteristics (e.g. religion). The results are shown in table 15. Three respondents did not answer this question.

Table 15. Frequencies for the conscious hiring of migrant care workers.

Conscious hiring of migrant care workers	Frequencies	Percentage
Yes	12	18.8
No	52	81.2
Total	**64**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

The respondents who answered yes on the question above, got a second question about what the motivation is for care organizations to consciously hire migrant care workers. The answer options were 'more diversity in care organization', 'better quality of care for care receivers with a foreign background', 'improved communication with care receivers' and 'a different reason'. The results are shown in table 16. The respondents who chose for the option of a different reason mentioned that it was a combination of the three other reasons and to provide better care for care receivers with a foreign background.

Table 16. Frequencies for reasons for conscious hiring of migrant care workers.

Reason for consciously hiring of migrant care workers	Frequencies	Percentage
More diversity in organization	4	33.3
Better quality of care for care receivers with foreign background	3	25.0
Improved communication with care receivers	3	25.0
Different reason	2	16.7
Total	**12**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

6. Learn and work programs

Another question was whether the care organization co-operates in learn and work programs. These programs combine learning and working. If a participant successfully participates in the program, he or she has a chance to get a job at the organization where he or she did the program. The results are shown in table 17. Three respondents did not answer the question.

Table 17. Frequencies of co-operation in learn and work programs.

Co-operate in learn and work programs	Frequencies	Percentage
Yes	28	43.8
No	36	56.2
Total	**64**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

The respondents who confirmed that the care organization co-operated in learn and work programs got the question if migrants participate in their program. The results are shown in table 18.

Table 18. Frequencies for if migrants participate in learn and work programs.

Migrants in learn and work program	Frequencies	Percentage
Yes	19	67.9
No	9	32.1
Total	**28**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

After this question, the respondents who answered yes got another question. This question contained how many migrants participate in the learn and work program. Four respondents did not know this. The results are shown in table 19.

Table 19. Frequencies for the number of participating migrants in learn and work programs.

Part migrants in program	Frequencies	Percentage
(Almost) all participants are migrants	1	6.7
About 75% of participants are migrants	0	0.0
About 50% of participants are migrants	1	6.7
About 25% of participants are migrants	7	46.7
(Almost) no participants are migrants	6	40.0
Total	**15**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

7. Diplomas

Also asked in the questionnaire was if migrants did apply for vacancies with foreign diplomas. In table 20 are the results shown for this question. Four respondents did not answer this question.

Table 20. Frequencies for if migrants apply for jobs with foreign diplomas.

Migrants applying with foreign diplomas	Frequencies	Percentage
Yes	38	60.3
No	25	39.7
Total	**63**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.

Another question was whether the care organizations do accept foreign diplomas and if they do under which conditions. The option answers are 'yes, all diplomas are accepted', 'yes, but only EU-diplomas are accepted', 'yes, but only diplomas generally accepted in the Netherlands are accepted', 'yes, but a different reason' and 'no'. The respondents who chose the answer 'yes, but a different reason' mainly answered that they accept diplomas which are valued in the Netherlands, which is the same answer as 'yes, but only diplomas generally accepted in the Netherlands are accepted'. Those two answer options have been combined. Another option was to answer 'I do not know', which was chosen by nine respondents. Four respondents did not answer the question at all. Results are shown in table 21.

Table 21. Frequencies of the acceptance of foreign diplomas.

Acceptance foreign diplomas	Frequencies	Percentage
All diplomas are accepted	0	0.0
EU-diplomas are accepted	1	1.9
Diplomas valued in NL are accepted	50	92.5
No foreign diplomas are accepted	3	5.6
Total	**54**	**100**

Source: Questionnaire 'Migranten in de ouderenzorg', 2012.