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Barriers versus promotion: Culturally sensitive healthcare for elderly Turkish migrants in Austria and Germany

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Abstract

What is the perception of Turkish migrants in elderly care? The increasing number of elder migrants within the German and Austrian population is causing the challenge of including them in an adequate (culturally sensitive) way into the German/Austrian health care system. Here I introduce the perception of elder Turkish migrants within the predominant paradigm of intercultural opening of health care in Germany as well as within the concept of diversity management of health care in Vienna (Austria). The qualitative investigation follows a field research in different German and Austrian cities within the last four years and an analysis based on the Grounded Theory Methodology. The meaning of intercultural opening on the one hand, and diversity management on the other hand with respect to elderly care will be evaluated. Whereas the intercultural opening directly demands a reduction of barriers to access institutional elderly care the concept of diversity is hardly successful in the inclusion of migrants into elderly care assistance – concerning both, migrants as care-givers and migrants as care-receivers. Despite the similarities between the health care systems of Germany and Austria there are decisive differences in the perception and inclusion of migrants in elderly care that is largely based on an 'individual care' concept of the responsible institutions. Finally, this investigation demonstrates how elderly care in Germany and Austria prepares to encounter the demand of 'individual care' in a diverse society.

Keywords: diversity; elderly care; intercultural opening; ageing Turks in Europe.

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Barriers versus promotion: Culturally sensitive healthcare for elderly Turkish migrants in Austria and Germany. A comparative approach

Introduction

My investigation is focused on the former '*guest-worker*' migrants from Turkey who came in the first instance during the wave spanning from the 1960s to the early 1970s to Austria and Germany, and, have entered the retirement age today. What to do when they need assistance in mastering their daily life? What kinds of services exist? How do migrants solve medical problems when they do suffer from illness and chronic diseases, dementia, or bedriddenness? What about elderly care when Turkish migrants need health or daily care?

This paper is part of a four-year study carried out in different larger cities of Germany and Austria based on a field study in order to investigate the perception of Turkish migrants in elderly care as a part of the health care system.

The recorded problems of elder Turkish migrants are diverse and often start with the lack of information and their insufficient German language skills to express their needs without a translator. It can be observed that elder migrants may have a certain reservation against nursing homes, often because of language barriers and divergent culturally shaped expectations expressed by meal preferences, a pronounced sense of shame, or religion. When elder Turkish migrants suffer from severe or chronic disease younger family members are in many cases not able to cope with the situation and the care of elder ones.

These problems are not quite distinct between Turkish migrants in Germany and Turkish migrants in Austria. This situation in general should challenge programs and special offers in elderly care that try to solve the question: '*How to include migrants' special needs in elderly care and how to implement a culturally conscious care?*' Despite the commonly observed problems and a similar approach in both countries that strongly connects migrant issues in elderly care with integration policies (Rechel et al. 2011, p. 189), there are regional differences in how migrants' needs are implemented in elderly care and even in how strongly migrants' needs are observed as such. As an anticipated result, the perception of Turkish elder migrants is different in both country's health care systems.

Method

Field research was carried out in different cities of Germany (Berlin, Hamburg, Munich) and Austria (Vienna). The cities are quite comparable in their number of inhabitants, ranging from nearly 1.5 million people (Munich) to about 3.4 million people (Berlin) in the year 2013. The percentage of foreigners, classified as inhabitants with foreign passport, ranges from 13.4% (Hamburg, Berlin) to 25.4% (Munich), the percentage of Turkish citizens (Turkish inhabitants) varies between 2.5% (Vienna) to 2.7% (Munich) (Statistics). The total number of inhabitants with a Turkish migration background (including those who now possess German or Austrian nationality) can be estimated to be around 5% for the above mentioned cities.

The field research included an investigation of the local health care system and health care providers and how migrants are included. The data was primarily collected by interviews, but also by a survey of brochures of municipal and private health care services and offers, newspaper and internet articles. Data evaluation on field notes and interviews followed the Grounded Theory Methodology as introduced by Glaser and Strauss (Glaser & Strauss, 1967; Denzin & Lincoln, 2005). However, the here presented results deal only with one partial aspect of the current study on '*barriers*' and '*promotion*' of a cultural conscious elderly care for Turkish migrants, therefore, this article will not refer to the main categories but focus on the results of

the field research and the question, how Turkish migrants are included in elderly care, and how their special needs are perceived. The results are discussed in comparison between Germany and Austria.

Results and Discussion

Intercultural Opening

In Germany, elderly care for migrants in general is strongly influenced by the paradigm of '*intercultural opening*'. Intercultural opening in health care can be described as a process of conceptual restructuring of municipal and private organizations responsible for the health care system towards the inclusion of migrants by reducing access barriers. The intercultural opening of the health care system follows an intercultural opening process of the education system and of the labour market. According to Wolfgang Hinz-Rommel intercultural opening is not only a socio-political demand but a necessary development in improving Germany's welfare system (Hinz-Rommel, Barwig, 1995). Besides the many different aspects of intercultural opening mentioned, the '*inclusion*' of all members of a society can be regarded as the key aspect.

Intercultural opening in elderly care thus focuses on the reduction of access barriers for migrants. The so-called '*Arbeitskreis Charta für eine kultursensible Altenhilfe*' developed within a project, a '*Memorandum*' in 2002 where they state that '*the access to elderly care in Germany should not depend on social, ethnic, or cultural background*' and a '*culturally sensitive and competent treatment*' should be provided by care-givers (Forum für eine kultursensible Altenhilfe, 2009). The culturally sensitive and competent treatment is not reduced to an '*equal treatment*' of patients but emphasizes a '*congruent treatment*' on the basis of equivalent values. Importantly, this Memorandum was signed by all welfare organizations in Germany. The intercultural opening process of stationary and ambulant elderly care of public (welfare) or private institutions is regarded to be in the beginning. The necessary structural transformations (for example, recruitment of migrants, intercultural competency training of the staff, etc.) have slowly been made during the last years. Much faster the awareness about culturally sensitive elderly care and intercultural opening has increased.

Today the inclusion of migrants in elderly care is observed in two ways: as care-givers on the one side and as care-receivers on the other side. Migrants are employed in hospitals, daily clinics, homes for elderly, and, they are themselves employers running a home or daily care agency. An increasing number of elder migrants take up information services, and also home and daily care offers with regional differences: the larger Turkish communities in Berlin and Hamburg seem to be more open to accept home and daily care than Turkish migrant community in Munich, for example. However, in Berlin and Hamburg there are also more offers (including culturally specific health care offers as discussed in the next chapter) for elder Turkish migrants compared to Munich.

The increased awareness about culturally sensitive elderly care has also triggered the collaboration between migrant associations and municipal institutions leading to a dialogue, the exchange of ideas and the initialization of projects. As an example, Saim and Fatma Çelik from the intercultural seniors' club *Mekân* in Hamburg, have initiated the opening of a Turkish based group in one senior residence of the town in 2009. In this group, Turkish halal-based meals and gender-based hygiene are provided to the patients by a Turkish speaking staff. Another project for Turkish seniors is planned (interviews with Saim and Fatma Çelik, Hamburg 07/2010 and 02/2013). This example shows that the process of intercultural opening and its success demands active collaboration and involvement of migrants. The above example of a specific initiative in Hamburg demonstrated further that addressing the needs of elder Turkish migrants strongly

depends on representatives from the same ethnic community. Fatma and Saim Çelik had to convince Turkish elderlies and their relatives to accept professional care in the culturally sensitive station. However, their common ethnic background and finally their collaboration with the senior residence mediated trust (interviews with Saim and Fatma Çelik, Hamburg 07/2010 and 02/2013).

Culturally specific health care offers

Besides the intercultural opening of health care institutions culturally specific health care providers have been established in different German cities with a particularly high density in Berlin. These providers of home or daily care offer a culturally oriented elderly care and advertise a native language based care and information as well as understanding of the client due to the employment of a staff with the same cultural background. This culturally adapted service is specified in more detail as obeying certain habits, customs as well as special forms of politeness.

Even though culturally specific health care offers for elderly are not programmatic for the intercultural opening of the health care system they can be viewed as a result of an intercultural opening of the labour market that not only allows but also encourages migrants to establish themselves as investors and employers founding their own service. These services are largely known for Turks, Russians and East-Asians. The majority of the clients of Turkish providers have a Turkish ethnic background and their services mainly run in districts with a higher Turkish population.

In Berlin providers of an ethnic-based daily and home care service for Turkish migrants have established around the year 2000. In the first years only a handful home care services focused exclusively on Turkish clients existed. Their economic success and the increase in the number of clients triggered the business of Turkish-based home care services. Today, there are at least 22 different providers in Berlin in competition for Turkish clients. An exact number of agencies for a culturally specific elderly care focused on Turkish migrants cannot be given because it rapidly changes.

The perception of Turkish migrants within the culturally specific health care offers is two-fold. Turkish migrants or people with a Turkish migration background act as employers or investors on the one hand, and are the highly desired clients on the other hand. This leads to an offensive ethnic-based advertising of the contents and offers within the culturally specific services.

The concept of diversity in health care

In contrast to Germany, the health care system in Vienna is governed by a diversity concept. The general meaning of the term '*diversity*' is a variety accentuating of '*differences*', and it has become a key term in management. The positive connotation of diversity is related to an (economic) advantage due to utilizing a plurality instead of a singularity or having a whole bundle of diverse options and solutions instead of only one. In terms of employees or team members of an organization their diversity is favoured suggesting a best possible recruitment and usage of resources in the battle for profit. The concept based on diversity is thus not primarily originating from a socio-political demand such as inclusion or equality. The latter merely can be consequences.

The '*Diversity and Integration Monitor*' first published in 2010 (Magistrat der Stadt Wien MA 17 Integration und Diversität, 2010) called '*Measuring integration, shaping diversity*' should summarize the integration status of the population of Vienna. The entanglement of both terms

diversity and integration anticipates that integration is the target of all municipal management. This has consequences for the health care system as well as on the perception of migrants within the health care system. The aim of offering the best care for everybody reads as a promise for the integrated ones. There is a conceptual difference between the intercultural opening policy and the diversity approach: Whereas the intercultural opening process aims to advance inclusion of migrants by reducing access barriers (which is seen as the task of the institution), the diversity concept in Vienna first demands integration from migrants (and thus leaves the task of reducing barriers to the migrants).

Both, *Fonds Soziales Wien* (FSW) and the *Wiener Krankenanstaltenverbund* (KAV) are responsible for health care in Vienna and offer multilingual advice center and information brochures, but concrete culturally sensitive health care offers for elder migrants are still missing (Magistrat der Stadt Wien MA 17 Integration und Diversität, 2010, section '*Healthcare & social issues*' p. 83 – 94). Not solely information brochures in native language but a native-language based care is needed. The municipal council for health is informed about the situation of elder migrants but does not support ethnic-based solutions, mainly based on financial arguments (interview with August Gächter, Centre for Social Innovation, 12/2014).

Since the diversity concept of the health care system in Vienna has not yet managed to establish local programs of elderly care with a culturally sensitive or culturally specific character, it has to be discussed if the barriers are of structural or conceptual nature (or of both) and how they can be reduced.

Conclusion

Despite the similar problems of elder Turkish migrants in Germany and Austria their perception within the health care system and the availability of culturally sensitive or culturally specific offers are distinct. The cities of Berlin, Hamburg, Munich, and Vienna were investigated in more detail.

The intercultural opening of the health care sector can be observed as the dominating policy in German cities. The concept of intercultural opening and the Memorandum have shaped the awareness of migrants' special needs and have triggered the activity of the migrant communities towards a dialogue with authorities and municipal institutions. Simultaneously, the intercultural opening of the labour market – an earlier development in Germany – has made employers or investors with migration background, who today are running a culturally specific elderly care agency. Therefore, the perception of migrants in elderly care in German cities is two-fold: they are recognized as clients with special needs and they are recognized as care-givers, nurses with special cultural and language competency, and as employers. The appearance of migrants as employers and as professionals in health care in turn creates trust, which seems to be the basis for any acceptance of a health care service by elder migrants.

In contrast, Vienna's health care policy is dominated by the diversity concept. This concept has basic differences in the perception of migrants in elderly care. The awareness of the special needs of elder migrants is low. Culturally sensitive or culturally specific solutions do not exist for the elder Turkish migrants. At the same time, there is also a lack in community based activities towards a solution of the problem. Thus it can be suggested that there might be inherent structural and/or conceptual barriers to a culturally sensitive elderly care for migrants in Vienna.

Finally, a culturally sensitive or culturally specific elderly care must be regarded as a possible individual choice of patients and clients. The often propagated individual care concept that is based on biographical work in elderly care is not sustained without having this choice.

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Statistics for the different cities are taken from *Statistik Austria* (http://www.statistik.at/), *Statistische Ämter des Bundes und der Länder* (www.statistik-portal.de), *Amt für Statistik Berlin-Brandenburg* (https://www.statistik-berlin-brandenburg.de/), *Statistisches Amt München* (http://www.muenchen.de/rathaus/Stadtinfos/Statistik/Bev-lkerung.html) and *Statistisches Amt für Hamburg und Schleswig-Holstein* (http://www.statistik-nord.de/).