CARE NEEDS OF ELDERLY MIGRANTS IN AUSTRIA

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Abstract: ***In Austria, migrants who arrived in the 1960s and 70s ("guest workers") were often supported very little in terms of language classes, education and other integration measures, as they were expected (and often themselves expected) to return to their country of origin eventually. In fact, most "guest workers" and their families became permanent residents. Now, the ageing of this generation of unexpected residents poses myriad challenges to the Austrian health care system. Although these challenges were foreseeable, care providers and state institutions have been reluctant to respond or are only lately beginning to respond to migrants' needs, in particular the need of language translation services and culturally sensitive approaches.***

This paper provides an empirical perspective on these challenges from ex-Yugoslav, Turkish and Philippine elderly migrants' point of view. For them, three topics interlink: On the individual level, they often face difficult access to a health care system that is not reflective of migrants' needs; at the level of the older generation – their own parents and in-laws –, responding to care obligations for relatives still residing in the country of origin conflicts with the regulations of migration regimes; and at the level of the younger generation – their children –, there are many open questions and tensions around care expectations which the younger generation may be unwilling or unable to fulfil.

The paper is based on a research project funded by the Austrian Ministry of Foreign Affairs and Integration, which aimed to analyse care needs and expectations of elderly migrants from the origin countries of ex-Yugoslavia, Turkey, and the Philippines. Methodologically, the study is based on analysis of literature and a quantitative estimate of migrants in elderly care for the next 10 years. Furthermore, 30 interviews with Austrian experts in federal administration, care providers, professional networks, relevant NGOs, as well as academic experts were conducted. Finally, the study aimed to explore

migrants' perspectives through 8 focus groups with overall 74 participants organized in the cities of Linz and Vienna.

Keywords: ***ageing; elderly migrants; care needs; culturally sensitive care; migrants' health***

Introduction

Making use of EU funding from the European Integration Funds, in autumn 2013, the Austrian Ministry of European Issues, Foreign Affairs and Integration contracted a study on the care needs of elderly migrants to the International Centre for Migration Policy Development in Vienna[1]. The study aimed both to take stock of existing data and to identify data gaps. A further goal was to gain an overview of the perceptions both of professionals in this field and migrants on the needs linked to the ageing of resident migrants in Austria. This empirical perspective was gained through semi-structured interviews with experts, and focus groups with elderly migrants of Turkish, ex-Yugoslavian and Philippine background in the cities of Vienna and Linz.

In this paper, we aim to summarise the study while also providing additional information on the Austrian context. We first provide an overview of the history of labour migration in Austria, as it pertains to the migrants' groups studied in BEMIG, and then give some insight into the demography of elderly migrants in Austria. We furthermore discuss the structure of the Austrian care system in order to provide an understanding of the system faced by elderly migrants in Austria. We then go on to discuss empirical findings, first from the expert interviews and secondly from the focus groups with elderly migrants.

The study can be accessed in full from the webpage of ICMPD's Research Department (http://research.icmpd.org/).

Labour migration history in Austria

After the end of World War II, Austria was a latecomer in the recruitment of labour migrants. Whereas the UK and France started to recruit workers in

[1] Betreuungs- und Pflegebedarf älterer Migrant Innen: Bedarfsabschätzung und Herausforderungen (BEMIG).

their former colonies in the 1950s, and Germany recruited in Spain, Italy and Turkey from the early 1960s, Austria signed the first recruitment agreements with Spain, the former Yugoslavia and Turkey in the late 1960s. First, economic recovery had not been as speedy as in Germany (indeed, until the 1970s many Austrians, mainly from the Southern provinces Carinthia and Styria themselves migrated to work in Germany and Switzerland) – and secondly Austria had received large number of "Volksdeutsche" ("Ethnic Germans"), originating in the former Czechoslovakia, in the 1950s, and they filled the open positions in industry and trade (Perchinig 2010: 20). Unlike Germany, where the electrical industry and car manufacturing offered solid income and career perspectives, Austria did not recruit for its heavy industry. The electrical industry and the steel industry were mainly state-owned and did not recruit foreign labour, as recruitment was linked to political patronage. Austria instead recruited for positions in the building sector, cleaning, the textile industry, trade and tourism. These jobs were not only low-paying, but also did not offer the prospect of career development. Labour migrants from the former Yugoslavia and Turkey thus tended to concentrate at the bottom of the job hierarchy and within the two lowest deciles of the income distribution (Perchinig 2010: 28).

Austria's recruitment policies followed the idea of "job rotation". It was envisaged that labour migrants would stay for a year or two and then return to their country of origin and be replaced by new personnel. In fact, employers were reluctant to dismiss trained staff after such a short time, and also most workers extended their stay. When recruitment was halted after the oil crisis and immigration was restricted, family reunification surged for fear of further restrictions. Temporarily-recruited labour migrants became permanently-resident immigrants. Migration politics did not react to this change, however, and upheld the illusion of temporary migration – an illusion shared with many migrants themselves, who often also believed in their return and frequently invested their savings in houses and apartments in their country of origin while living in low-standard housing in Austria (Perchinig 2010: 15).

Many immigrants recruited in the 1970s and 1980s have now reached the age of retirement. Nevertheless, according to a study in 2006, only one third were convinced that they wanted to stay in Austria, the others wanting to return or to commute between Austria and the country of origin. Most migrants interviewed tried to postpone the decision to return, and thus were also reluctant to mentally prepare for ageing (Reinprecht 2006: 133).

In the BEMIG project, we aimed to analyse this group further, starting with an analysis of available demographic information.

Demography of elderly migrants in Austria

Who are Austria's elderly migrants? According to "Statistik Austria", the Austrian federal statistical service, there were approximately 275,000 foreign-born persons aged 60+ living in Austria as of January 1, 2014. The vast majority originate from a European country: Slightly more than a quarter of them were born in a state that was a member state of the European Union before 2004, almost one third in one of the countries that have acceded to the EU since 2004, and approximately one third in other European countries, including Turkey.

Table 1: Foreign-born aged 60+ by region of birth, 2014

	2014	%
EU member states before 2004	76,559	27.85
EU member states since 2004	88,277	32.12
EEA, Switzerland	3,066	1.12
European Third Countries (incl. Turkey)	87,035	31.66
Asia (without Turkey, Cyprus)	13,228	4.81
Others, unknown	6,706	2.44
TOTAL	274,871	100

Source: Statistik Austria, Stat-Cube database, authors' calculations.

Within this group, five large groups of origin can be discerned: Persons born in Germany are by far the largest group (approx. 55,000 persons), followed by persons born in Serbia and Montenegro (approx. 37,500). Migrants born on the territory of the Czech and the Slovak Republic form the third largest group (approx. 26,000) followed by approx. 24,000 persons born in Bosnia and Herzegovina and approx. 17,500 persons born in Turkey.

This distribution reflects the complex history of Austria as a destination country for labour migrants and refugees. While migrants aged 60+ born in Serbia and Montenegro and Turkey came to Austria through "guest worker" recruitment in the 1970s and 1980s, the majority of persons born on the territory of the Czech and Slovak Republics are "ethnic Germans", who fled or were

expelled from the former Czechoslovakia after World War II. Approximately half of this group now is over 75 years of age. A small proportion of the elderly migrants from Bosnia and Hercegovina are "guest workers" from the 1970s and 1980s, but the majority fled to Austria during the course of the Balkan wars in the 1990s.

Table 2: Foreign-born over-60-year-olds, major age groups and countries of origin

Country of birth	**60–74**	**75+**	**total**
EU member states before 2004	49,369	27,190	76,559
of which:			
Germany	38,297	17,343	55,640
Italy	3,547	3,547	7,094
EU member states since 2004	56,023	32,254	88,277
of which			
Croatia	8,548	3,562	12,110
Poland	10,011	2,823	12,834
Czech Republic	14,100	12,160	26,260
Romania	5,722	4,278	10,000
Slovenia	6,114	3,614	9,728
Hungary	6,715	3,675	10,390
Non EU European Economic Area (EEA)	2,044	1,022	3,066
Other European Countries (incl. Turkey)	72,425	14,610	87,035
of which:			
Bosnia and Herzegovina	21,120	2,648	23,768
Serbia, Montenegro	29,577	7,990	37,567
Turkey	15,452	2,042	17,494
Africa	2,456	385	2,841

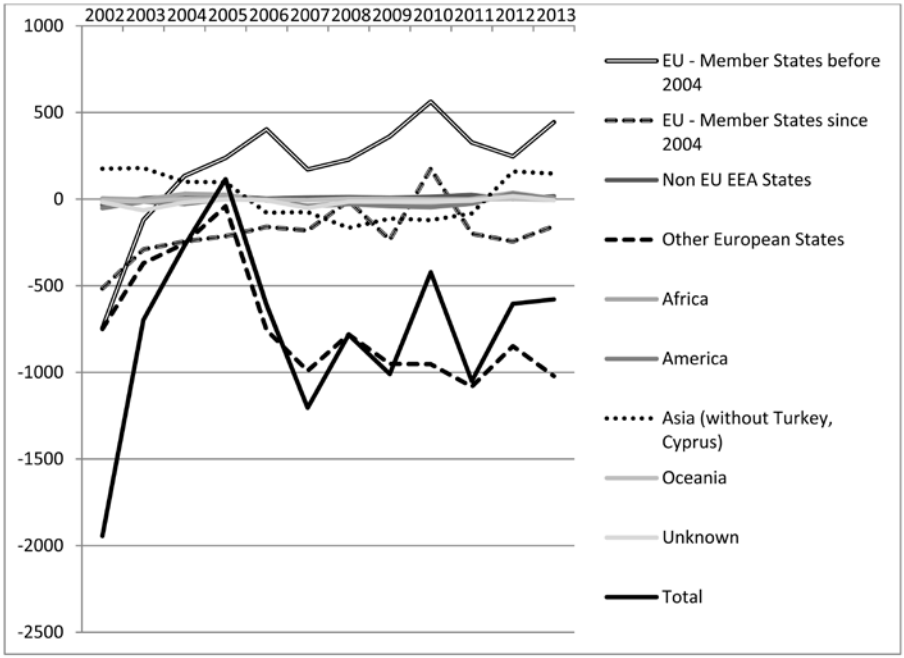
America	2,656	819	3,475
Asia (without Turkey, Cyprus)	11,012	2,216	13,228
of which			
China	1,180	242	1,422
Iran	2,374	753	3,127
Philippines	1,818	138	1,956
Oceania	172	27	199
Unknown	121	70	191
TOTAL	**196,278**	**78,593**	**274,871**

Source: Statistik Austria, Stat-Cube database, authors' calculations.

Currently, both emigration and immigration by persons aged 60+ is low. In relative terms (net migration in years x/total population in year x+1), there has been nearly no influence of migration movements of persons aged 60+ on the stocks of migrants aged 60+ in most years since 2003 (-2% to + 1.8%). The ageing of the migrant population thus is the result of demographic ageing, and not of immigration: virtually anyone living in Austria at the age of 60 will most likely also die in Austria. There are no statistical signs of "immigration into the care system", as discussed in the Austrian media recently.

The publicly available demographic projections of Statistik Austria do not allow a breakdown of age cohorts by country of birth, but only give a broad overview by birth in Austria and birth abroad. According to these data, in 2020 approx. 15.4% of the population aged 60–79 and approximately 11.10% of the population 80+ will have been born abroad, and by 2025 these shares will increase slightly to 15.92% and 11.99% respectively. The total number of foreign-born aged 60–79 will increase between 2014 and 2020 by 19.6% and by a further 13.6% between 2020 and 2025. The increase in the age group 80+ will amount to 18.5% between 2014 and 2020 and to approx. one third between 2020–2025. Thus, the group of elderly migrants is becoming ever more relevant.

Diagram 1: Gross migration of population 60+ by region of origin, 2003–2014



Source: Statistik Austria, Stat-Cube database, authors' calculations.

The Austrian care system: Structure and uptake

For historical reasons, the Austrian system of elderly care is characterised by a huge variety of service providers, ranging from private companies to aid organisations affiliated to the churches or political parties, and municipal or provincial institutions. The governance of home care and residential facilities, like the training of care professionals, is regulated, planned and funded by the nine regional governments, while the management of long-term care allowance payments ("Pflegegeld"), a flat rate contribution to the costs of care, is administered by the federal government.

This long-term care allowance is the most substantial subsidy for care paid out to individuals. It is paid out on application to all citizens and (most) legal residents in need of care, when this is proven by a medical case analysis organised by the regional governments. The long-term care allowance, intended

to give patients choice and to prolong the time span they are able to spend in their own home, has led to a shift away from away from residential care, with only 16% of beneficiaries of the care allowance living in residential care facilities in 2010 (Hofmarcher – Quentin 2013, quoted in Schuhmann et al. 2015: 2). Patients are free to decide on how to spend the care allowance, and thus informal and family care still covers the majority of care needs, despite the growth of institutional provision, particularly in mobile care (Rodrigues et al. 2012). A further prevalent type of care is 24-hours care, provided by live-in care workers. This sector has become a kind of replacement for residential care for the middle classes which can afford the fees and can offer the care worker a room in their homes. As migrants only rarely make use of this option, it will not be discussed further here.

Aside from these private arrangements based on the long-term care allowance, institutional care provisions can be divided roughly into three categories:

a) Mobile care, ranging from support for household work to simple medical interventions (changing dressings, injections etc.)
b) Residential care
c) Semi-mobile care, ranging from day centres for the elderly to part-time residential care

As mentioned, both mobile and residential care is implemented by a variety of organisations. In each of the nine provinces different governance frameworks and institutional landscapes have developed. Despite these differences, a few major providers play a dominant role, in particular the Red Cross associations, Caritas (linked to the Catholic Church), Diakonie Austria (linked to the Protestant Church), Volkshilfe (close to the Social Democratic Party) and Hilfswerk Österreich (close to the Conservative Party). In most provinces, the regional government and the municipalities also act as providers of residential care facilities for the elderly.

The system of care allowance funds both mobile and residential care. In mobile care, the recipient receives the care allowance directly and has to pay individually for the care provisions provided. In residential care, both pension or other income and the care allowances are paid to the care provider until the cost of care is covered. The client receives 20% of his/her pension plus Euro 45.20 monthly as pocket money (plus the remains of his/her pension if it is higher than the cost of care). If the costs cannot be covered by the retirement pension

and care allowance, the difference is covered by the regional government, which is entitled to claim the patient's property to cover the costs. With effect from July 1, 2014, the duty of children to cover the costs of care for their parents has been abolished[2].

The care allowance is an income-related benefit paid out monthly. As of January 1, 2014, there were seven levels, defined by the required hours needed for care. For patient's with severe disabilities surcharges are paid.

As the care allowance is related to different levels of need of care, data on care allowance uptake can be used to estimate mobile and residential care usage. According to figures published by the Ministry of Labour and Social Affairs, 454,843 persons were receiving care allowance payments as of August 1, 2014. The table below illustrates the distribution by gender and level of care allowance paid out.

Table 4: Care allowance users by level of care allowance and gender (2014)

	Care need (hrs/month)	Women	Men	Total	%	Allowance/ month
Level 1	at least 65	71,305	34,301	105,606	23.22	EUR 154.20
Level 2	at least 95	83,353	46,714	130,067	28.60	EUR 284.30
Level 3	at least 120	50,721	28,308	79,029	17.38	EUR 442.90
Level 4	at least 160	41,099	22,968	64,067	14.09	EUR 664.30
Level 5	at least 180	31,992	15,358	47,350	10.41	EUR 902.30
Level 6	at least 180 + need for permanent surveillance	11,584	7,523	19,107	4.20	EUR 1,260.00
Level 7	at least 180 + immobility	6,210	3,407	9,617	2.11	EUR 1,655.80
Total		**296,264**	**158,579**	**454,843**	**100.00**	

Source: BMASK 2014: 150.

[2] The funding system has a clear disincentive against residential care: Since in most cases the pension payment and care allowance are not sufficient to cover the cost of care, the regional government will often claim the property of the patient's bestowals. In this case, asset transfers within the three years preceding the take up of residential care are void. Thus in most cases both patients, who want to stay at home as long as possible, and children, who are the future heirs of the property of their parents, will try to organise family care or mobile care for as long as possible to prevent the patient's property to be claimed by the regional government.

The latest available figures on the usage of the care allowance by type of care refer to data from 2010 (BMASK 2012). According to this evaluation, 53% of all recipients used no institutionalised care at all, but had organised care informally within the family, while 29% made use of institutionalised mobile and 16% of institutionalised residential care provisions. 24-hour care was used by 2% of the recipients of care allowance. According to a study of the Fonds Soziales Wien (FSW 2014), users of institutionalised mobile care usually receive care allowance at the levels 1–3, whereas the majority of patients in residential care homes receive care allowance at levels 4 upward.

As the table shows, about two thirds of care allowance beneficiaries (65.14%) are women. More than half of care allowance beneficiaries receive care allowance at levels 1 and 2, and approx. one third (31.46%) at levels 3 and 4. Care allowance at levels 5–7 is paid to approx. one sixth of the recipients.

Care allowance is not only paid to elderly persons, but to all persons in need of care. Nevertheless, the vast majority of recipients are aged 60+ (women: 87.16 % men: 71.49 %). Within this group, care allowance uptake is much higher in the age group 80+ than in the age group 60–79 (59.77 % vs. 9.32%). On average, persons aged 80+ receive care allowance at levels 4–9, whereas the majority of persons aged 60 79 receive care allowance at the levels 1 to 3.

It is difficult to draw any conclusions on uptake patterns of elderly migrants from these data. There are no data available on the usage of care allowance for different types of care provisions by nationality or place of birth. According to experts interviewed for the study, these data are not collected due to data protection considerations and the fact that care providers do not see them as necessary for care provision, and are reluctant to ask clients about sensitive data.

Empirical results

The empirical study aimed to identify major challenges linked to the ageing of migrants from the perspective of care providers and professionals in the field, and of migrants themselves. It was based in part on 30 semi-structured interviews with experts from care providers, care administration at the state and local level, and NGOs working in the field of integration, which aimed to identify the perspectives of the respective social fields.

The perspective of migrants was explored by eight focus group discussions with migrants from the former Yugoslavia, Turkey and the Philippines, comprising approx. 50 attendants. The discussions were organised with the support of

partner organizations from the health sector and migrant counselling organisations. All group discussions were held in the first language of the participants (for Philippine immigrants in English), and were recorded and transcribed or summarised. Both the expert interview protocols and the group discussion protocols were analysed using the MAXQDA software package.

Migrant ageing: Main challenges from experts' point of view

Information and outreach to clients

Most experts interviewed agreed that migration was of growing importance in their institutions. Initially, migration issues had been linked mainly with recruitment, as the share of migrants among staff had started to grow massively in the last 10 to 15 years. Meanwhile, the growth of migrants among clients has also started to attract a growing amount of attention.

Public outreach to migrants was identified as a major issue for the future by most interviewees. Most care providers mentioned that they had multilingual printed material available, but only a few also had their web pages translated into the migrants' main languages. According to several interviewees, existing outreach practices were only seldom based on a thorough analysis of migrants' communicative needs, going beyond the written material. Elderly migrants most often approach their relatives and friends as a first source of information, and, due to past negative experiences with the authorities, shy away from contacting the public administration. Thus in order to reach elderly migrants, who often are neither familiar with the Austrian care system nor fluent in German and are unlikely to make use of the internet, face-to-face communication and the presentation of information at meetings of migrants' associations are crucial. According to several interviewees, personal communication is the key to reaching migrants as potential clients.

Legal and economic barriers to access

As most elderly migrants in Austria are hold a long-term residence permit or have been naturalised, and thus also have access to public care payments, legal obstacles to accessing care provisions for the elderly were rarely mentioned by experts. Since, however, public care payments usually are not sufficient to pay all the costs related to mobile care, and elderly migrants often live on a minimum pension, several experts stated that in practice access to mobile care is often severely limited. This is particularly relevant for semi-mobile arrangements,

such as for instance day care centres, which offer day care for clients and thus prevent them from having to move to a stationary home for the elderly, but charge relatively high costs for care. In connection with the complex application procedure for the reimbursement of costs, and the lack of information about support for low income clients, often available only in German, potential clients shy away from making use of mobile services.

Several experts also pointed to a problematic element of the Austrian care subsidy model: Care subsidies are paid out to the client, who is able to decide how to use them. In many families care subsidies for an elderly family member are considered to be part of the household income, and thus there is reluctance to use mobile care providers. In family contexts characterised by a strong moral obligation to take care of elderly family members, which is the case in many migrant families, there is a tendency to perceive the hiring of external care services as a "failure of the family", which results in pressure on (female) spouses and children to engage in intra-family care arrangements, even at the price of quitting their job.

Challenges in mobile care

Mobile care arrangements may range from household support to support with personal hygiene and medical support. Being delivered in the home of the patients, they imply the crossing of the boundary of the private space of the client. Not only is a stranger allowed into the flat, but s/he also takes over household tasks that go to the heart of personal autonomy (cooking, cleaning, shopping), and thus clearly communicates a loss of autonomy to the client. If the client also needs support with personal hygiene, the boundaries of the body are also at stake, as a stranger intrudes into the intimate sphere.

Several experts stated that this structural challenge of mobile care for the elderly – negotiating the place of a stranger in one's private and intimate realm – is further complicated in the context of care for elderly migrants, if the care worker is not familiar with the language and culture of their clients. The development of a positive care relationship needs to involve trust-building both with the client and with family members. Both require the intercultural training of staff, particularly in the case of Muslim families, where family obligations to provide care for the elderly are strong, extra-family care has a bad image, and everyday life is governed more strongly by religious rules than in other cases.

A further aspect related to care quality mentioned by experts is continuity of staff. The schedules of mobile care providers usually foresee 4–8 care workers

per patient, who alternate in visiting the clients. The funding schemes for mobile care moreover demand a scheduling of mobile care teams based on the principle of minimal travel time between the homes of the clients As such a frequent change of care workers is experienced as stressful, most institutions follow the model of "primary care", where one care manager is available as a continuous contact person, and there is as much continuity in the team as possible, although the high staff turnover in mobile care challenges this approach in practice. In this respect, most interview partners complained about the growing time pressure on mobile care, which de facto reduced mobile care to functional care, neglecting the need for a good personal relationship between clients and care workers.

Language Matching

For related reasons, language matching between clients and care workers is seen as a major challenge by most interview partners. Most elderly migrants are not fluent in German, and prefer to talk in their first language with their care workers. Most interview partners agreed that the ability to communicate in the first language of the clients not only eases communication, but also furthers trust and good personal relations. Furthermore, several interviewees noted that a growing number of clients suffer from dementia, which negatively impacts their capability to communicate in German.

According to the experts interviewed, in practice there are only limited capacities for language matching, since mobile care teams are set up based on a scheme of minimal cost, as already mentioned above. There is no right to first language care in the Austrian health care system overall, and quality regulations do not define language matching as a quality criterion. Thus, there is no funding for the organisation of mobile care teams according to this principle. All interview partners agreed on the need to change quality definitions of care with respect to language matching, but also were extremely sceptical of reaching this goal, as care budgets had been cut due to austerity measures in social funding, and politicians in charge of care policies supposedly were not interested in migrants' needs.

Gender matching

Experts see the gender matching of care workers and clients as a particularly sensitive issue with regard to caregiving for elderly migrants. According to expert interview partners, most mobile care providers try to avoid matching male care workers with female clients, which is an absolute taboo for Muslim clients. Since the workforce is predominantly female, these cases are rare, but

female care workers often have to care for male clients. This setting is accepted hesitantly by male clients; traditionally-oriented male clients, in particular, do not accept it well, according to experts. Most interview partners stated that they try to inform their clients if a care worker from the other gender is on duty. If clients refuse the visit, they try to find a solution on a case-by-case basis.

Several experts suggested broadening the notion of care quality to include the question of gender matching; gender matches not accepted by the client should not be understood as a failure of the client to accept care, but as a failure of the organisation to provide quality care.

Religious issues

Religious issues in the field of mobile care are focused on two aspects: religiously determined dietary laws, and staff awareness of religious rules relevant for everyday life. Whereas in Vienna, at least, most providers of "meals on wheels" offer meals without pork and vegetarian meals, there are no "meals on wheels" providers offering "halal" or "kosher" meals; these meals have to be provided by the families concerned. In many cases, however, care workers prepare food at the home of the clients and they need the necessary training, which is not foreseen in most cases.

Several interviewees voiced concerns about the lack of training of care workers in everyday religious rules. According to experts, nurses are often not aware of the importance of regular prayers for Muslim clients, and interrupt them when praying; it was not known that wearing street shoes in an apartment is deemed a gross discourtesy, that a commode should never be placed in the direction of Mecca, etc.

In this context, the adherence to Ramadan rules, particularly the drinking ban during the day, was mentioned as a severe challenge, as from a medical perspective adherence to the drinking ban could be dangerous and negatively affect the effects of medication. These issues demand a sensitive dialogue with the clients and, if necessary, the involvement of a Hodja or another religious leader to convince the client that medical reasons mean s/he does not have to comply with Ramadan rules.

According to several interviewees, religious issues gain importance in old age, so clients also pay more attention to the observance of religious rules. Care workers who are not adequately trained may perceive this insistence on religious rules as "troublesome" or rebelliousness, a potential conflict which should be eased by better intercultural training for nurses.

Challenges in residential care

Recent years have seen a significant change in the role of residential care. Whereas in the 1990s a large number of residents in residential care homes were still relatively mobile, all stakeholders in the field of care today agree on the principle of privileging mobile support over residential care for as long as possible. According to the interview partners, this development has led to a major change in the age composition of inhabitants of residential care facilities, who today tend to be in their eighties, and are much more in need of intensive care than average residents were in the 1990s. This shift towards mobile care has also reduced the demand for residential care.

In effect, residential care homes today have to reach out for residents, several interview partners mentioned, and in order to gain more clients, they are starting to recognise migrants as potential new target groups.

In this respect, the image of residential care among migrants is of specific concern. In general, residential care homes suffer from a bad image fuelled by cases of mistreatment of patients, although quality control measures have improved the situation, several interview partners stated. Migrants distrust residential care even more than the autochthonous population, as they judge them based on the quality and image of residential care homes in their countries of origin. Furthermore, strong family values prevent families from making use of residential care facilities, since arranging residential care for a parent is often seen as a massive moral failure on the part of the family. Several interview partners reported that residential care providers had thus started contacting migrants' organisations to make their offers known.

Although residential care providers reported very low percentages of migrant clients (3–10%), they mentioned challenges similar to those for mobile care, in particular language matching, language issues linked to dementia, and the inclusion of family members in care activities.

Language matching

Language matching is an issue linked to both the composition of staff and of residents. Many migrant residents are not fluent in German and prefer to communicate with the nurses in their first languages, which is not possible in most cases, many interview partners stated. Where the languages spoken by staff match those of the clients, the providers try to include the issue in staff planning. Compared to mobile care arrangements, stationary arrangements

make it easier to match the languages spoken by staff and by clients, as the number of staff is higher and both staff and clients live in the same building.

As well as language matching between clients and nurses, language matching between residents is also an issue. According to several interview partners working in residential care, regular contact with peers speaking the same first language is of great relevance for patients suffering from dementia, as in phase II of dementia people lose the ability to communicate in languages learned later in life. Without regular communication in their first language, these patients withdraw from communication with the outside world, and dementia progresses faster. According to one expert, only a few nursing homes for the elderly in Vienna have already realised the link between dementia and first language communication, and try to organise activities for their residents suffering from dementia in settings allowing communication with peers from the same area.

Regarding first language communication, most respondents pinpointed the need to value the language skills of employees as an important resource for granting care quality for migrants. Although it is rarely possible to extensively cover all the first languages of the residents, language matching ought to be an issue in staff recruitment. The possibility for patients to interact in their preferred language with inmates and visitors should be defined as an element of quality in care. At the moment, providers seek case-by-case solutions, but there is a need for a more systematic approach.

Gender matching

Much as in the mobile sector, the issue of gender matching was also addressed by interview partners as a relevant aspect in residential care, although the greater number of employees meant the issue could be solved more easily. Moreover, due to the female dominance of the nursing profession there have hardly ever been situations where a male nurse had to assist a female patient in personal hygiene. These settings are avoided as far as possible with regard to Muslim patients, the interviewees confirmed.

Religious and cultural aspects

According to the majority of interviewees, integrative concepts granting patients the right to follow their religious and cultural traditions within a residential facility open to people with different religions and cultural backgrounds are better able to link care quality with cultural sensitivity than facilities catering only to a specific group. Religious services for all major religions are offered in public

residential homes for the elderly, and religious dietary requirements may be easily followed. The role of religion in everyday life is the choice of the individual, and no problems were reported with regard to these issues. In practice, however, there are only a very few migrant residents, particularly only a very few Muslim residents, living in residential homes in Vienna and Linz, so the issue may gain more prominence in the future when the number of migrant clients rises.

Migrants' views of care: Results of the focus group discussions

Unmet needs of migrants in the Austrian elderly care system: Getting the information right

The following sections are based on the interpretation of focus groups with elderly migrants from Turkey, ex-Yugoslavia and the Philippines, held in Linz and Vienna. In this section we analyse our participants' statements through focusing on how three important requirements are not being met in order for migrants to navigate and access elderly care in Austria. First of all, information policies are not proactive, and information is often only in German, while at the same time information about the current care system and what to expect there is strongly lacking amongst migrants. Secondly, and relatedly, first language speakers and/or translators are either not at all or only barely represented in institutions. Thirdly, and again linked to language, acceptance of cultural diversity is a topic that has barely started to register with providers; migrants fear racism and non-acceptance because of their "otherness": their own customs, care needs and wishes, and their language. In these three major ways, the needs of migrants in the elderly care sector are not met and this contributes to migrants not accessing the system.

Regarding difficult access to information, three issues meet in a problematic way: migrants' scepticism towards state institutions; taboo-like and fatalistic attitudes that surround care outside of the family; and a politics of health care information that sees it as migrants' own responsibility to be informed, rather than the other way around.

How can one access public information about care? As already described, the elderly care system is extremely complex and there are many considerations to take into account before deciding which offer might be the appropriate one in a given situation. Information about these various possibilities is scattered and cannot be easily accessed. This does not mean that there is no effort at all in terms of providing information. Care providers, both in the form of large

state institutions as well as the individual providers themselves, offer online and offline information about their services, often in the form of folders that are also put on the respective website as documents. Some, but not all institutions, have translated these brochures into the most common languages in Austria, but they are not specific to the questions elderly migrants may have.

The general problem of access is not specific to migrants, but is a problem for the population in general: Information is scattered, demanding a high degree of search activity from the user, and a middle class educational background to understand the information provided. How do elderly migrants deviate from this implicitly assumed norm? For many participants in our focus groups, problems had already accumulated over the years. Many of them were poor, meaning that they received near or below the minimum retirement pension. Many migrants of this generation have, like our participants, only learned very limited German, since they worked in manual labour, while women who often did not enter the workforce never found an opportunity to learn it at all. After years of hard work, these elderly migrants have often aged faster than the average population and have already acquired severe health problems. Poor migrants in need of care thus find themselves being sent from service to service, never able to explain themselves properly, since the system does not seem built for them and the language is not theirs.

These common experiences, reiterated throughout the focus groups, have also shaped our participants' attitudes toward state institutions, including those state institutions responsible for providing elderly care. (Despite the fact that elderly care is often sub-contracted to NGOs and Catholic Church agencies, participants in the focus group often stereotyped all providers as "the state".) Especially amongst women and in the Turkish focus groups, there was a strong fear of "interacting with the state"; because they could not speak the language properly and were thus not able to explain their situation adequately, there was a fear of "losing out" in interacting with state agencies. One female participant in a Bosnian/Serbian/Croatian group said: "I am afraid of losing what I have, if I interact with a state agency." Another woman stated:

> *I have experienced things. When you go somewhere, to get information and when they sense that you cannot speak German that well... Often, often, often, it is dependent on the person sitting there whether you get it or do not get it. Whether she will give you the information or not. Or she just says, no, you do not have a right, a claim. Simply, she cannot be bothered to look, or to work, or she does*

not want to be bothered with an explanation, or to show that she is listening to you, that she understands what you want.

However, not only attitudes towards the state overall are at stake in accessing information; there is also the more specific question of what is thought about care institutions. Most participants in our focus groups had a very limited knowledge of elderly care services in Austria. Most participants were only aware of in-patient care, stereotyped as "homes for the elderly". At the same time, this type of care was met with great distrust and fear. An exception to this was the Filipino group, as most participants were employed in the care sector and were thus knowledgeable about the system.

Care in a nursing home – usually referred to as a "home" – was perceived as the worst scenario amongst most focus group participants, across all groups. As in the Austrian majority population, care at home, and by family members, was seen as the ideal. Care in a "home" was connoted emotionally and morally with feelings of fear of mistreatment and being let down by relatives. There was talk of parents being "deported" to "homes" by their uncaring children; people in homes are those who were "thrown away" by their families; "homes" are only for poor or extremely sick people. One woman in a Turkish focus group (Linz) summarised: "A care home is a place where people are rounded up!"

Thus, for some participants there seemed to be almost a taboo surrounding the topic, which has implications for information-seeking behaviour. Some participants spoke of attempts to talk about elderly care options with their parents that failed, either because of their parents' or other relatives' strong feelings about it. One example of this was a participant from the ex-Yugoslavian women's group (Vienna), who also did not perceive care in a "home" as appropriate. To the assembled relatives in the family home in their country of origin, her brother had suggested accessing in-patient elderly care for their mother. The participant recalled: "And everyone jumped up: Are you not ashamed to put your mother into an elderly home? She does not deserve this." Another participant in the Turkish women's group (Vienna) critically reported a recent experience in her job as a counsellor to other migrants:

I was talking about this with a family only today. The daughter wanted to talk to me about care institutions and already in the first phase of the conversation, the mother complained and was offended. She said: "You don't want me and you want to stick me in a care institution."

This participant was critical of this attitude: it should at least be OK to access information. Both examples show the strong moral assessments and feelings that are associated with the topic of care: guilt, duty, "punishment", being offended, feeling hurt, feeling rejected, etc.

Another attitude prevalent amongst participants was a certain fatalism and a lack of proactive searching for information. This is a general phenomenon for health care topics – difficult health situations are an unwelcome topic that few like to think about if they are not acute. In the focus groups, it did become apparent that the lack of information about options beyond the fearsome "home for the elderly" exacerbated this issue. Because "homes" were associated with such strong fears, they were only seen as the very last option, in case of emergency. "Only if we have an emergency situation, will we become active," a female Turkish participant expressed the sentiment of many others across the focus groups. Care outside of the family is seen as the very last resort.

All of these attitudes contribute towards an aversion towards looking for information with regard to the elderly care system. It is somewhat of a vicious cycle – since there is a lack of information about the broad spectrum of care (aside from "homes"), migrants do not perceive institutional care as a viable option, and thus do not look for information. Such a cycle can only be broken by first-language, culturally-appropriate, sensitive and proactive information. Experts interviewed for our study and focus group participants all agree that brochures are not enough to process the complex information of the care system, and to cut through the broader social issues involved. Counselling services are needed, places where trust can be built and fears are understood. However, while there are plenty of counselling services available for German speakers, these services are barely available in other languages. Non-German speakers often have to resort to going to small NGOs catering to migrants, whose main focus is usually not on the topic of care.

Thus, migrants' needs are intentionally or unintentionally ignored and an informed, middle class, German-speaking subject is implicitly assumed. These issues are now starting to be addressed with small pilot projects that have proactive/outreach approaches, but broader, mainstream strategies towards inclusion of migrants are still utterly lacking.

Migrants' needs in care service: language issues

Moving on from the question of information, how are migrants' needs addressed within care services themselves? Among the most obvious gaps is the question

of languages offered by care providers. While most care providers and other experts interviewed agreed on the fundamental importance of first-language competence of professional careers, if the clients do not speak German, the reality does not match this assessment in the slightest. As mentioned above in the analysis of experts' interviews, attempts to match the first language of clients with that of the care worker are still very limited in extent. There is no right to first-language care in the Austrian health care system overall; for care institutions, language matching is not part of quality assurance.

The importance of first-language care for migrants cannot be overstated. It was the primary concern throughout all focus groups. Even for those participants who spoke German well, there was a fear of not being able to communicate personal issues with subtlety. One participant put it this way: "I have worked here myself, I have a pension here, I can make myself understood, but the mother tongue is something else. It would be important, because then I can say anything and be sure that everything will be understood."

Furthermore, second languages learned later in life can deteriorate or be completely lost in old age, especially in the case of dementia. One participant in a Bosnian/Serbian/Croatian group was worried:

> *As long as we are working, we speak German well enough. Later on you don't use the language any more and you talk less. When you talk less, your capability in (the language) diminishes.*

The issue of first language care also strongly related to the fears and stereotypes of being cared for in a "home". The fears of being mistreated and helpless in a closed institution multiply because of the language barrier. Lacking German, one would not even be able to make a complaint. "This is what we are afraid of, that we do not know the language and we cannot communicate our problems," one female participant in the Bosnian/Serbian/Croatian group stated.

The concerns regarding mobile care were similar: in order to take the fearsome step of letting a stranger into the house, one at least wants to be able to communicate with them. Implicitly and sometime explicitly, focus group participants assumed that a first language speaker would be a person of trust in a care institution, one who did not ignore the "foreigner", took concerns seriously and sorted out misunderstandings. As with the provision of information, there is a clear connection between first-language care and trust in the institution.

A less dramatic, but still important concern with regard to language was the question of social contacts. Many participants voiced a desire to be able to make new contacts in a care institution, to talk about life experiences: "The problem is, I won't be able to have dialogues, to make friendships." In one women's group, there was even enthusiasm for the idea of being able to meet lots of other women in a similar situation at the end of life: "Old people want to talk and tell stories a lot, so a day-care institution would be good!" a Turkish participant offered. However, this enthusiasm was quickly overshadowed by the question of whether speaking a non-German language would even be welcome in such an institution.

Migrants' needs in care service: Cultural sensitivity

Another participant shared the story of her mother, who had suffered a stroke shortly after having fled from ex-Yugoslavia to Austria. She thus had to go to hospital without any knowledge of German. In these unknown surroundings, her mother's traumatic experiences during the war resurfaced, and she believed she was in a prisoners' exchange. The participant said:

> *And this she remembered well, the exchange. (...) So, she should be exchanged, and she is waiting, she is waiting for her turn. All the others are Chinese. That was a horrible thing, to explain to her that she is in Austria, what can I (tell) you. (...) At least she (could) recognise us, everything else was real suffering.*

This participant's story illustrates the importance of care in a first language, in order to understand what a patient/client is going through. Together with participants' concern about talking in a non-German language in a care institution, it also highlights how the issue can even go beyond language, as a certain cultural and historical knowledge can be required to provide appropriate care to an elderly migrant.

Focus group discussion often cumulated in this third unmet need: Participants wanted care providers to be sensitive and welcoming of cultural diversity. This started with obvious points often also iterated by experts, such as having a choice between a male or female care worker, especially in intimate care; culturally/religiously appropriate meals; or religious needs such as prayer rooms. Beyond such perhaps more easily ticked off lists, there was a strong wish for cultural, ethnic, religious and language acceptance. One participant summarised it in the following way:

> *It would be important to me that the staff also respect and accept culture, rituals, eating habits. Because people who accept another culture – it feels good when you know that they are people like that.*

Such a broad understanding of culturally-appropriate care is thoroughly lacking throughout the Austrian elderly care landscape. Some providers interviewed, who favour a strong needs-based approach in their in-patient care, were also realising that this was where they needed to grow as an institution in order to fulfil their high standards of care for migrants as well. But even these providers were only starting to think about how they might go about realising such care and to start to respond to migrants' needs in elderly care.

Care for the family abroad

In the previous section, attitudes towards care "homes" have already been described: for focus group participants, "homes" were the worst option, while care at home by family members was the ideal. Especially in the women's focus groups, participants talked at length about the care arrangements they had made for their own parents, in many cases without any institutional support. Many participants had parents or in-laws who were living in the country of origin, which poses a moral and an organisational difficulty. Participants had found different solutions to this problem, which we will now describe: trying to get their parents to come to Austria; having care provided in the country of origin; and shuttling back and forth in order to provide care.

(1) A self-evident solution to having a relative in need of care in another country is to try and bring that relative to one's own place of residence. However, in most cases this idea failed for policy, organisational and/or emotional reasons. Some participants said that they could never remove their parents or in-laws from their usual surroundings, as this would make them deeply unhappy. Another participant in the Turkish women's group (Vienna) said that she and her eight siblings wanted to bring their mother to Vienna from Turkey. This participant's own flat would have been too small to house her. In terms of rooms, it would have been possible for the mother to stay with a brother, but the idea finally failed as the daughter-in-law in question "did not want it".

But the biggest obstacles are still the relevant policies: participants reported having trouble in fulfilling the relevant requirements, such as proving a certain income for their parents and health insurance. Thus, relocating an elderly relative to Austria is possible in theory, but difficult in practice.

(2) Failing the option of bringing relatives to Austria, there were three options reported by focus group participants wishing to care for them from afar. One was that other family members took care of parents/in-laws – surely one of the easiest solutions. A number of participants reported sending money to the respective care-taker in order to contribute something. Another participant in the Turkish women's group reported that it might also be possible to engage neighbours as care workers, as was the case for her mother:

> *I recommended that she go into a home. But she has very good neighbours. Her neighbours are very helpful and they support her with anything. My mother gives them the money for the shopping and the neighbours go shopping for her and also cook for my mother.*

A third option was to arrange mobile care. Although not as widespread as in Austria, this was an option for one participant's mother. She reported that her siblings had put together the money to arrange for a care worker and meals on wheels. However, she reported that this only worked less than ideally: "Mother was not happy with this (and) always complained." She did not eat the food.

(3) A third option, which for obvious practical reasons seemed to be prevalent mainly among participants from the ex-Yugoslavian group, was to shuttle back and forth between the country of origin and Austria, sometimes even to go back for longer periods of time to take care of a relative. One participant in the ex-Yugoslavian women's group said that after her father, living in the country of origin, had suffered a stroke, she had cared for him there, with some help (mainly of a financial nature) from her brother: "We kept up the idea that one should help one's parents, me and my brother". Since she was on parental leave anyway and not working, she lived with her parents "down there" for a while. After this period, she shuttled back and forth every second week-end. "We did as much as we could, my brother and I," she emphasized her self-sacrificing attitude.

In the Turkish women's group, following through with this idealism worked out less well. One participant reported that she had relocated back to Turkey for a few months in order to support her mother who needed care. This participant does not have family herself and lives on welfare ("Notstandshilfe"). When she travelled to live with her mother, her problems multiplied. She lost her claim to welfare but still had to pay her rent in Austria. Her mother had been afraid of going into a "home" because of a fear of violence there and a fear of losing her social contacts. Her mother had a very low income and she had not been able

to find anyone to take care of her reliably on such little money. This participant was herself very worried about what would happen in the future, should she one day need care herself, as she did not have any children to take care of her.

Expectations and changing family structures

In this last empirical section we show why, despite all the challenges and despite migrants' own doubts and fears about institutional care, the state care system will be important in the future, also for elderly migrants in Austria. For most elderly migrants in our focus groups, care in the family is seen as the ideal care arrangement, an attitude similar to that of the majority population. Even more than in the majority population, there are sometimes very high expectations of the younger generation and the duties they are expected to fulfil. Throughout the focus group discussions, major lines of discord did occur, however, pointing towards a change in values and attitudes in the 2nd and 3rd generation, having largely to do with changing gender roles of women. Tracing the lines of discussion in the focus groups sheds a light on the major fault lines in these discourses.

(1) During the focus groups, the topic of expectations towards children was usually started when participants spoke of their own experiences in caring for parents or in-laws. As was discussed in the previous section, most participants tried very hard to take care of their relatives personally, within the family. Many spoke of the family's "duty" towards older relatives in this regard, which was a motive across all focus groups. Fulfilment of this "duty" was a strong moral norm, and certainly created high expectations of many participants towards the younger generation. One participant in a women's Bosnian/Serbian/Croatian group in Vienna expressed her expectations in the following way:

> *Our tradition in the Balkans is that the family lives together and that we are very connected. And we expect, me, all of us, (...) we made everything possible for our children and now we expect of our children, when we are old, that they take care of us.*

Similar discussions took place in the Turkish groups, where one female participant said: "Of course everybody wants their own children to take on the care." Another said: "Surely my five grandchildren will take care of me." Some female participants also explained that people become more sensitive and emotional in old age and want to be treated with care, looking for closeness with one's children.

In the Filipino group, the discussion was slightly different. At first, participants emphasised that they did not want to burden their children, but then one participant did say: "If you really love someone", you also do the care work – a very high expectation of children. Another said: "I experienced this myself: Working full-time, taking children from a to b, getting them to kindergarten...", but another replied to her loudly: "Yes, and we survived it, too!" The previous participant laughed at first, but then she agreed: "We want to experience this, too", implying the self-sacrificing devotion and sense of duty expected of the children.

A similar attitude was prevalent in the discussion of the men's group in Linz, where one participant first expressed understanding for children who did not always conform to the "attitudes" of the "first generation" any more. He himself had learned that one must "always take care of one's parents", as he said. The "second generation" children, however, have in his view taken on the attitudes of the Austrian population that there are, after all, good care services available. Thus, parents do not need to be cared for personally any more.

While this participant laid out this narrative in a distanced way, another instantly reacted with strong emotions. If this were the case, he would disown his children and give his belongings to the care home. "I have taken care of my children so far, and even now although they are grown up. And when I am old, I am supposed to be cared for in a home, and not by my son?!" This notion outraged him.

A participant in a women's Bosnian/Serbian/Croatian group (Linz) expressed her expectations quite clearly: "I cannot imagine going to a home for the elderly. I believe in Allah and rely on my children. I have also cared for my parents-in-law and hope that my children will do the same for me."

(2) These narratives on the one hand express quite clear expectations: Children have a duty to take care of parents(-in-law). Since people had performed care work themselves, there was an analogous expectation of children. But there were also some sparks of doubt and quiet criticism within these parts of the discussion, some suggestions that things were not as they used to be. At this point in the focus groups, a certain perception of social change entered the discussion.

There were also those participants who did not want to "burden" their children. To this participant's story, another replied: "Actually, children don't want to take on the care work at all, but we just don't look into our options as much as we should." Another participant also wanted to avoid troubling her children based on her own experience:

I am registered in a (care home), I know the care facilities. I have a child, but I cannot expect this of my child, because I know how difficult it is to take care of infirm people at home.

Another male participant in the Bosnian/Serbian/Croatian group said that everyone is used to the family taking care, based on experience in the country of origin. But he was critical: "The family has a duty to take care of infirm (relatives). But the reason for this is partly because there is no other option."

Starting to discuss social change, many participants offered the idea that there is a big difference in expectations of care between "nowadays" and "back then", and between the country of origin and Austria. Women were usually not working in a job. In many focus groups, people pointed out "how little time" their children had – both overall and for their parents. This kind of talk also implies unspoken ideas about gender and care, since although there was always talk of "the children" who had no time, it became clear further down the discussion that it was really the female children that were implied. Women in the family are responsible for care work, but since many of them are now working in a job, this brings great change.

This change of "not having time" for parents and other relatives is further exacerbated by the changes in household structure. Participants told stories of how care used to be arranged in extended family households and thus did not form such a big burden on one single person. Filipino participants also emphasised that there were always helpers employed in the family household who would help with care work. Now, the distance between multiple small family households also enters the equation. A number of participants shared their experience of having to travel across the city to take care of relatives, in addition to doing their job and caring for their own children. A participant in a women's Turkish group thought it would be easier to have the parents in her own apartment, but it was just too small:

The apartments (in Vienna) are small and are just about sufficient for your own family. But if the parent who is in need of care lives elsewhere, how often can you visit them or support them. After all, you have your own family on the other side with your husband and children.

This perception of social change was accompanied by a perception of change in the children themselves. Throughout all focus groups, there were

discussions of how children did not conform to old norms and moral expectations any more – a fairly universal theme for first generation immigrants, perhaps. As one participant put it: "The children are not what they used to be, either." How was this "difference" portrayed? For instance, one participant in the women's Turkish group in Linz said, she did not want to go into a "home", but she did not trust her children to take care of her either, as they did not live close to her. A participant in the women's Bosnian/Serbian/Croatian group in Vienna shared a story about her son:

> *I was sick for two months myself, but it is no use to me whatsoever that my son is close by. He does not even want to buy my medication for me. Children are completely different nowadays. They don't have humanity like we do.*

Another agreed:

> *They also don't have any feelings. For some things. When he sees, that someone is sick, he should get up. But he waits until you tell him to. And then, when you tell him to go shopping, he will do it or he will quickly walk away and say: we'll do that later.*

These narratives are about certain ways of behaving around respected persons, which the parents know from their own upbringing, but the children apparently do not any more. This theme recurred throughout all focus groups. A participant in the men's Turkish focus group (Vienna) summarized: "We all have the same problem, that our children do not think like us anymore."

(3) For some participants, weighing all these different factors brought ambivalence and a sensation of being overwhelmed. Some were unsure what to expect of their children and were torn between not wanting to burden children and the strong desire to be cared for by them. Two examples show this most clearly.

In the women's Bosnian-Croatian-Serbian group, a participant expressed her wishes in the following way: "The question of what would I decide for myself tomorrow is clear for me without a doubt: a home for the elderly. Why? First of all, I would not want... It is absolutely clear, that the children cannot... They say, 'Mama, but no'." In this narrative, the participant on the one hand says clearly that she would be willing to go into a care facility. On the other hand, she imagines her children contradicting her and saying "no, Mum". She further elaborates that it is most important for her that nobody has a "bad conscience", least of all her children. This shows a great wish for harmony in family relations.

A female participant was similarly ambivalent:

> *It would be okay for me to go into a care home. But if my children were here (now), they would surely be offended and say: "Mama, what are you saying. I am there for you."*

This imaginary dialogue shows a strong wish for the children to take on care work of their own accord, without there being any conflict.

Part of the ambivalence, furthermore, seems to lie in the difficulty of even addressing the topic. Participants mostly did not actually know their children's stance and were perhaps afraid to ask, hence the imagined dialogues. One participant said that her husband was completely ignoring the topic. She herself assumed that their children would not do care work at all. But she could not discuss the topic of ageing with her husband, because he would instantly "block" the topic when she addressed it. She also mentioned only speaking very limited German herself, so she is worried about her future care.

(4) The reaction of ignoring the topic was also particularly strong with those participants who either had no children, or no children living close by. Since so many expectations of care focus on the children's role, these participants seemed to be at a loss. In two focus groups, such participants remained silent throughout the discussion and only told their story when prompted by the facilitator. In the Bosnian/Serbian/Croatian group (Linz) there were two single women without children who said they would be on their own if they needed care. One of them said she was hoping that her nieces would take care of her. Another answered only hypothetically and evasively:

> *I hope and trust in God that this will never be the case. I would ask my neighbours, or I don't know, what would you do?*

In another group, there was also a single participant without children who lived off welfare and was in great financial trouble. She was afraid of what would happen should she need care, and had no scenarios for this. She also assumed that she would not be able to afford institutional care anyway.

In summary, the focus groups showed that care in the family, by one's own children, was the ideal for many participants, similar to the Austrian majority population. A motive that was perhaps stronger than in the majority population was the notion of duty of the children towards their elders. The focus groups at the same time also portrayed the strong social change that was going on in the

second generation, the participants' children. Compared to the situation these migrants knew, their children seemed "different". They have less time, the women are working, and the families live apart in smaller households. The reactions in the focus groups to all these hard-to-accept and hard-to-understand changes can thus be summarised as being of four types: (1) One group that, at least within the discussion of the focus group, refused to change their high expectations of their children; (2) A group that was already certain that children would not do care work, anyway; (3) Another group that was ambivalent; (4) and a few participants who were simply overwhelmed by the topic and thus tried to push it out of their minds. The respective attitudes seemed to be mostly connected to whether participants recognised that social change was taking place and that their children were in a different position than they had been. While the first group was not interested in the Austrian elderly care system, groups 2–4, for different reasons, developed a strong interest throughout the discussion. Be it out of "compassion" for the children, a simple acknowledgment of the children's situation, or out of a lack of alternatives, these migrants need the elderly care system to welcome them.

Conclusions

Both the expert interviews and the focus group pointed to four main areas in need of reform:

a) Information on the Austrian care system targets a middle-class audience with well-honed communication capacities, and does not reach migrants. There is a need for a more proactive and targeted strategy for communication with migrant communities, including outreach events organised together with migrants' associations and held in the mother tongue of major Austrian migrant groups. Special care should furthermore be taken to reach vulnerable groups such as (single) women. Even more than among the majority population in Austria, care outside of the family has a bad image among migrant families, who tend to judge it based on information about care providers in their country of origin. It is therefore necessary to provide face-to-face first language counselling in order to mitigate fears concerning institutional care services.

b) Language competency of staff in the first language of migrants is a crucial issue both in mobile and residential care arrangements. Language matching between clients and care workers needs to be defined as a criterion for care quality, and should be fostered wherever possible. Language matching is

particularly pertinent in cases of dementia, as dementia may lead to a loss of communicative ability in languages learned later in life. Both providers of mobile and residential care should be encouraged to take into account the communicative needs of patients both in the planning of activities with residents and in staff planning.

c) Both mobile and residential care arrangements need to train staff in intercultural awareness and develop plans for inclusive and culturally-sensitive care. In order to do so, it is necessary to collect further data on the usage of care facilities by migrants and on access thresholds. The communicative element of care has to be taken seriously in order to develop a sustainable relationship between clients, care workers and clients' families. Strong family obligations to support the elderly should not be seen as a barrier, but as a potential to improve care quality.

d) The lack of coordination between the provincial governments and the different care providers should be overcome by a coordination platform providing exchange of practices and common training with regard to ageing of migrants in order to better prepare the Austrian care system for the growing number of migrant clients.

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