J Health Serv Res Policy OnlineFirst, published on March 30, 2015 as doi:10.1177/1355819615577807

Original Research

Journal of Health Services Research & Policy
0(0) 1–7
© The Author(s) 2015
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1355819615577807
jhsrp.rsmjournals.com

Personal home care workers' role in hospital: a qualitative study

Liat Ayalon[1], Sara Halevy-Levin[2], Zvi Ben-Yizhak[3] and Gideon Friedman[4]

Abstract

Objectives: Unlike in most high-income countries, in Israel personal (social) care of elderly patients in hospitals is provided either by relatives or friends, or, for those patients with live-in assistance at home, by their home care workers. Our aim was to understand the explicit and implicit roles of live-in carers and whether any difficulties occurred.

Methods: Interviews in the internal medicine unit of Hadassah Hospital with 17 patients, 16 relatives, 20 home care workers and 20 nurses. Data were subjected to categorical content analysis.

Results: Three major themes emerged: the development of teamwork with relatives and nurses; the varied roles of home care workers including nursing care, emotional care, and monitoring and supervision of the patient; and the conflicts and challenges associated with having a care worker related to their physical presence and the care worker's own social needs.

Conclusions: Israel partially addresses its nursing shortage by allowing paid home care workers to take an active role in the care of hospitalized older adults. This can have both a positive and a negative impact on the role and perception of nursing.

Keywords

care of the elderly, Israeli hospitals, migrant care workers, nursing

Introduction

Israel has one of the lowest ratios of nurses to patients in the Western world (4.5 per 1000 people) compared with an average of 8.4 in OECD countries. The occupancy rate of beds in Israeli hospitals is almost 100% compared with 76% in OECD countries.[1] Given increases in life expectancy and the tendency for older adults to disproportionately use health care in general and hospitals in particular, some experts predict a medical crisis in Israel.[2]

Home care workers

The Israeli government attempts to limit institutional long-term care and to encourage care in the community. In 1988, a community long-term care insurance law was enacted with the goal of maintaining older adults in the community for as long as possible. Currently, insurance supports about 17% of older Israelis, with almost all of them receiving home care services. About one-third of home care services are provided by live-in (round the clock) workers. This role is usually provided by migrant workers from Eastern Europe or the Far East because there are few Israeli workers available for round-the-clock care.[3] The remaining two-thirds are provided with live-out Israeli home care workers. Services are rendered based on predetermined eligibility criteria, such as the older adults' physical and mental function, financial status and age.[4] As the purpose of the law is to support older adults in their own homes, older adults living in care homes are not eligible to have a live-in worker.[3]

[1]Professor, Louis and Gabi Weisfeld School of Social Work, Bar Ilan University, Israel
[2]Geriatric and Health Social Worker, Hadassah Medical Hospital, Hebrew University, Israel
[3]Senior Physician, Internal Medicine Unit, Hadassah Medical Hospital, Hebrew University, Israel
[4]Senior Physician, Head of the Geriatrics Unit, Internal Medicine Unit, Hadassah Medical Hospital, Hebrew University, Israel

Corresponding author:
Liat Ayalon, School of Social Work, Bar Ilan University, 52900 Ramat Gan, Israel.
Email: liatayalon0@gmail.com

Research has shown that migrant workers are at risk of abuse and exploitation.[5] This has been attributed to their temporary residency status and the nature of their round-the-clock work, behind closed-doors. Although they are usually more educated and of better socioeconomic status than the majority of people in their home country, in Israel they are often marginalized on the basis of their race, ethnicity, social class and sex[6] and tend to be in jobs that are dirty, dangerous and degrading, which are not wanted by Israeli workers.[7]

Given the characteristics of older care recipients, who by definition have to be impaired to employ a live-in worker, the chances are that many such workers will find themselves caring for their client during his or her hospitalization. For example, about 20% of new admissions of people over the age of 65 to an internal medicine unit in the largest hospital in Jerusalem were accompanied by a live-in migrant home care worker. This caregiving arrangement is not part of the job requirements of live-in workers and not officially acknowledged as legal.

Relatives and paid carers in hospitals

In Israel, 69% of hospitalized patients have a family carer, who provides an average of 8 h of daily care.[8] This is consistent with Korea where 87% of hospitalized patients rely on care mostly unpaid by family and friends.[9] Such high numbers of patients needing carers are attributed to high levels of patient dependency, high nursing workload and inadequate care provided by the hospital staff.

Within hospitals, relatives provide care alongside hospital staff, make major health care decisions for or with the patient, serve as mediators between the hospital staff and the patient and supervise the quality of care provided to the patient.[8,10–12] When paid carers are involved rather than unpaid relatives, they perform similar tasks: attendant, protector, friend, coach and negotiator.[13] Paid carers are required to negotiate their roles with patients, their families and other service providers[14] though they are likely to do so from an inferior position compared with family members as carers.[15]

Research on paid carers in hospitals in Korea and Israel reflects a substandard health care system failing to provide older adults with their basic care needs during hospitalization. As a consequence, hospital care is complemented by relatives with traditional values of inter-dependence and modern values of individualism and self-actualization. While some families incorporate a strong emphasis on care for older relatives, other families encourage women to join the workforce resulting in a more diverse and vulnerable family unit than in past generations.[16] In Israel,[12] paid carers act as an alternative. They are mostly foreign and are an attractive option given their willingness to provide care at a relatively low cost.[16]

Our aim was to explore the caregiving arrangement of live-in paid carers who accompany an older adult during his or her hospital admission. We were interested in the explicit and implicit roles of live-in paid carers and the presence of role conflict or role dispute within the hospital.

Methods

Sample

The study was carried out in the internal medicine unit of Hadassah Hospital. Selection of the patient sample aimed to reach maximum variation in terms of age, sex and education.[17] Eligibility criteria for patients were being 65 years or older, being accompanied by a live-in migrant home care worker and being cognitively and physically capable of participating in an interview. Eligibility criteria for family members were being the primary carer for an eligible patient. Most were children (81.3%). The eligibility criterion for migrant home care workers was being able to communicate in English or Hebrew. All nursing staff in the internal medicine unit of Hadassah Hospital were interviewed. We continued with data collection to the point of theoretical saturation (no new thematic content emerged from the interviews).[18] Table 1 presents the demographic characteristics of the sample. Patients had received a mean of 5.6 years (*SD* 10.3) of home care from migrant workers. They had a mean of 2.1 (*SD* 1.4) conditions and had spent 4.1 (*SD* 2.0) days in

Table 1. Demographic characteristics of the samples.

	Patients ($n = 17$)	Home care workers ($n = 20$)	Family members ($n = 16$)	Nurses ($n = 20$)
Age (years)	80.0 ($SD = 6.0$)	34.8 ($SD = 7.0$)	57.3 ($SD = 7.8$)	34.4 ($SD = 9.4$)
Sex (women)	70.6%	80%	68.8%	52%
Education (years)	10.8 ($SD = 6.4$)	11.5 ($SD = 2.1$)	17.0 (9.6%)	15.8 ($SD = 1.9$)

hospital. Home care workers had migrated from the Philippines (60%), Sri Lanka (20%), Nepal (15%) and Moldova (5%). On average, they had been in Israel for 4.1 (*SD* 2.1) years.

Procedure

Three social workers with training in qualitative research served as interviewers (conducting 5%, 25% and 70% of the interviews). Ongoing feedback was provided to interviewers to promote consistency in interviewing style. Interviews were conducted between July 2011 and April 2012 in Hebrew or English according to respondents' preferences. A funnel approach was employed during interviews, starting from broad questions, such as 'Tell me about your hospitalization/your care recipient's hospitalization', followed by more detailed questions, such as 'What are your expectations of the migrant home care worker during hospitalization'. Respondents were asked descriptive questions, such as 'Describe your role in this caregiving setting'. They were also asked analytic/interpretive questions, such as 'What are the advantages of having a migrant home care worker/family member during hospitalization', and comparative questions, such as 'How do you think the treatment would have been without a migrant home care worker present'. In addition, selected demographic questions were included to better situate the respondents in a sociocultural context. Interviews lasted 25–40 min. Whereas attempts were made to interview respondents in a quiet, uninterrupted environment with none of the other stakeholders present, this was not always possible given the nature of the hospital setting.

Analysis

Categorical content analysis assumes that the text follows detectable systematic repetitions. Data categories were coded in stages, with each successive stage representing a more complex conceptual level.[18] Each interview was first coded thematically for major content areas. Next, commonalities and differences across interviews were evaluated and themes were regrouped to represent major content areas that received considerable attention across participants. There was no attempt to force data into preconceived themes, but instead, an open coding approach that allowed interview data to guide the creation of the categories was employed.[19] To search for inter-theme consistencies and contradictions, descriptive and then interpretive categories were created to represent interview data. The final stage was selective coding, which involved the identification of core categories to create a storyline,[18] with the focus on migrant home care workers. LA conducted the analysis for each group separately, and commonalities and differences across groups were noted. Nvivo 7 was used for data analysis and storage. The other authors (two internal physicians and a social worker) reviewed the analysis, and their feedback was incorporated. Disagreements were resolved on the basis of a consensus.

Results

Three major themes emerged from the data: teamwork (a team consisting of the migrant home care worker and the nursing staff and a team consisting of the migrant home care worker and the family members); workers' roles in the teams that formed within the hospital (nursing care, emotional care, and monitoring and supervision) and potential challenges or conflicts associated with having a worker at the hospital. The themes are discussed from the point of view of all four stakeholders: migrant home care workers, older adults, family members and nursing staff. See Figure 1 for a pictorial presentation of the findings.

Teamwork

The concept of teamwork was present in many of the interviews though the concept of team varied. Nurses tended to include the migrant home care worker as part of the nursing team, whereas family members (primarily wives of patients) tended to describe the worker as part of their family team. Migrant home care workers expressed affiliations with both teams.

Nursing staff and workers as a team. Nurses were quite eager to include the workers as part of their team. This was primarily attributed to the high workload imposed on nursing staff but also to the similar nature of their work:

> 'Sometimes we are under a lot of stress, so it helps, it helps to have foreign workers. So when we see that there are foreign workers who actually help it really makes our lives easier'. The worker was a 40-year old woman with a Master's degree.

Some of the workers also spoke about the nursing staff in terms of a team and acknowledged nursing as a substantial source of help. A 46-year-old woman from the Philippines with a Master's degree commented:

> The nursing staff is so nice. They treat us very nicely. And they help me to take [my patient] to the shower and to change her diaper.

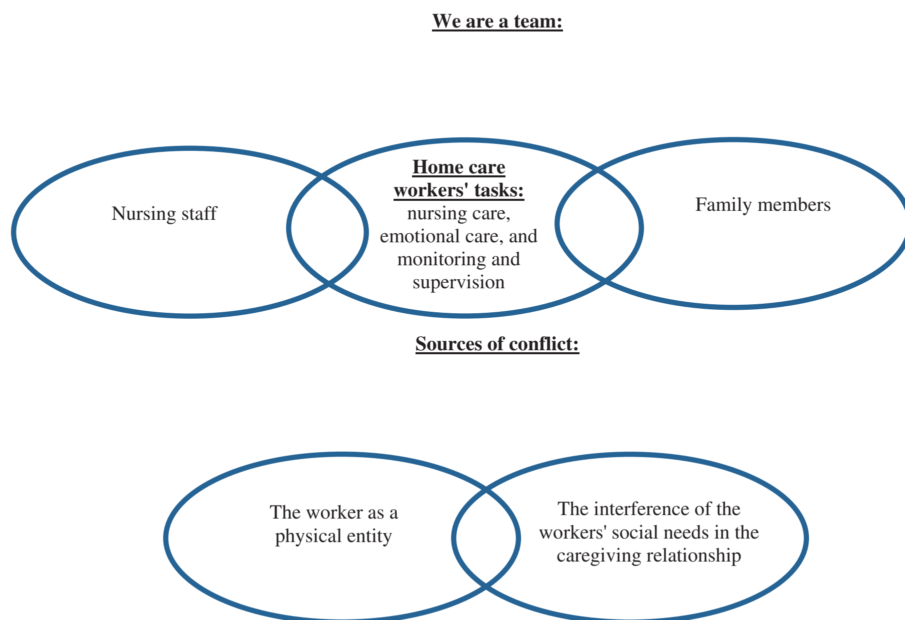

Figure 1. A pictorial presentation of the findings.

Family members and workers as a team. Family members, particularly the wives of older male patients, were inclined to describe the worker as a family team member. For many of the wives, having a worker meant having someone to share the physical load of caring. For others, it meant taking turns at the hospital. The following statement is from a wife who discussed her relationship with the worker, a 64 year old with 12 years of education:

> I wash him when she [worker] is not around, I change his diaper, I do all the things that she does . . . I take care of him and the worker, we take turns.

The workers themselves were less inclined to consider themselves to be part of the family team. They perceived themselves as having a very different set of roles from those fulfilled by the family. Nevertheless, some workers did portray their relationships with the family in team-like terms, as evident from this account by a 30-year-old home care worker from the Philippines with 12 years of education:

> When I give him [the patient] a shower, his wife makes the bed in the meantime.

Although adult children readily acknowledged the contributions of the worker to the care of their loved one, this was rarely discussed in team-like terms. Instead, adult children tended to acknowledge the workers' role as different from their own. This is demonstrated by the following statement made by a 55-year-old daughter of an older adult:

> I come to visit, but he has three [paid] care takers, one is in charge of making a schedule, one is in charge of establishing contact with physicians . . .

Workers' roles

Nursing care. The provision of nursing care, ranging from changing diapers to washing, feeding and giving medications, was acknowledged by all stakeholders. When asked to describe the workers' role, nursing staff often emphasized workers' involvement in nursing care. This is evident in the following quote about a 42-year-old worker with 15 years of education:

> They [the migrant workers] are more readily available, so in the time it takes the nurse to get to the room, the worker – after all he is sitting with the patient – so yes, he has already taken [the patient] to the restroom, given her water.

Older patients also acknowledged the role of the worker in the provision of nursing care though rarely portrayed as a major role. Nonetheless, the following quote demonstrates the level of assistance provided by

the worker and its perceived benefits as reported by a 82-year-old woman:

> The advantages of having a worker are that I can call her if I need something. 'Mary, I want water. Mary, I need the restroom. Mary, I'm hungry. I want to eat.' Everything, all these things I tell her.

Emotional care. Even though nursing care was identified as the most frequently engaged in of the workers' tasks, emotional care was portrayed by many as the most important, as the following quotation from a 46-year-old worker from the Philippines, with a Master's degree demonstrates:

> I just do my work properly because I love my work and I love my employer and she loves me too. It's not about the money, you know. It's about her [employer] being grateful . . .

Family members were also eager to acknowledge the emotional role the worker plays in the life of patients. The following is a description in which a son compares the relationship between his mother and her 53-year-old worker with 15 years education to a longstanding marital relationship:

> They [the worker and my mother] are human beings. It is very natural in my perspective that people who live together under the same roof, like a husband and a wife, sometimes fight. [The worker] and my mom are always together, so [my mom] sometimes complains that [the worker] is watching TV, that she isn't doing enough, but [mom] knows this is her security.

Nursing staff did not emphasize the bidirectional nature of the workers' care. They describe the relationship instead as more asymmetric, as going primarily from the worker to the patient. This was often contrasted with the nursing staff's perceived inability to provide such care. The following account from an interview with a nurse provides a good example of the perceived emotional role of a 32-year-old female worker with a Master's degree:

> We [the nursing staff] try to give the same treatment, whether there is family around who pressures us to provide care, or a foreign worker, or if the patient is alone and there is no one to request treatment. We try to give the same treatment, but emotionally, we're not usually able to sit by the patient. I mean, we can, but if there is someone around [like a worker], of course, that adds a lot.

Monitoring and supervision. Family members, workers and nursing staff all emphasized monitoring and supervision as one of the major tasks of the worker. Older patients, however, hardly acknowledged this role at all. In the following description, a wife emphasizes the advantage to having someone (a 62-year-old woman with 12 years of education) next to her husband at all times:

> We do everything together, the worker and me. We are the same. The good thing is that she can take over for me. I can't be there (in the hospital) for more than eight hours, so she replaces me and takes over for eight hours. That way there is someone with him [the patient] all the time. . .

The task of monitoring and supervision received the most emphasis in interviews with nursing staff. Many viewed this as the central role of the worker who can directly convey important information to nursing staff who are unavailable to monitor patients round the clock. As one nurse put it:

> If there is something out of the ordinary, they [the workers] are able to call the nurse or report to the nurse, so that I can come and see the patient.

Conflicts and challenges associated with having a worker

Conflicts and challenges associated with this caregiving arrangement were evident in interviews with all stakeholders. Many times, conflicts revolved around deviations from the worker's expected role.

The worker as a physical entity. This challenge received the most attention in interviews with nursing staff, who often felt the physical presence of the worker to be a major obstacle, given the limited space on the unit and the life-and-death nature of the care provided by the nursing staff:

> There is one disadvantage to having a worker. At night, with all those chairs in the room, they hardly allow you to move.

Another nurse noted:

> They [migrant workers] take up space and act like they're at home.

The interference of the worker's social needs in the caregiving relationship. The perception of conflict between the worker's social interests and his or her role as a care

provider emerged primarily in interviews with family members and nursing staff. The following statement reflected this concern from the point of view of the family members:

> It's possible that she [the worker] falls asleep from time to time [while taking care of the patient], but there is no way [the worker would spend time with her friends rather than care for father]. I have seen that many times [when other workers spend time with their friends rather than care for their patients]. We see foreign workers sitting outside, speaking in groups. She [our worker] is not going to be part of this [social gathering]. There is no way, we would come over and she would not be there [by the patient].

Discussion

Much has been written about the globalization of the nursing workforce, in which skilled staff from low-income countries migrate in order to meet the demand for nursing in high-income countries.[20] The Israeli case is different as both nursing staff and family rely on unskilled home care workers to provide personal care, traditionally performed within the private sphere in order to sustain a household. The work performed by migrant home care workers allows family members to continue providing personal care and nursing staff to undertake paid work that is actively contributing to the economy and has prestige. In contrast to many high-income countries that have dealt with their nursing shortage by importing nursing from low-income countries,[21,22] unofficially Israel at least partially addresses its nursing shortage by allowing for unskilled migrant home care workers to take an active role in the care of hospitalized older adults.

Researchers have argued for the blurring of the boundaries between paid and unpaid labour.[23] The present study adds to this by demonstrating this blurring of boundaries between formal and informal care, between nursing and emotional care and between paid and unpaid labour all within the hospital premises. Past research has demonstrated the family-like roles of migrant home care workers within the host family.[24] The present study reveals that care recipients, their family members and nursing staff alike expect the home care worker to provide emotional care. Family members and nursing staff are often too busy with other work. As a result, emotional care is left in the hands of the migrant home care worker. Similarly, much of the personal care such as cleaning or feeding that used to be performed by either family members or nurses are now performed by migrant home care workers.

Consistent with previous research,[13] the beneficial role of the home care worker in hospital was readily acknowledged by the various stakeholders. However, several sources of conflict also emerged. From the point of view of nursing staff and family members, these conflicts evolved when the worker deviated from fulfilling his or her expected role. The most pronounced case was the sense of the worker as a physical entity, taking up precious space. This conflict potentially represents a wish to keep the migrant worker 'invisible' in the eyes of society.[25] Another form of deviation from the worker's expected role centred on the worker's engagement in his or her own social life with other workers, rather than on the provision of round-the-clock care to the older adult. These two areas of conflict point to the dehumanization of the worker as a provider of labour, rather than as a human being with physical and social needs and wishes. This likely stems from the fact that Israeli society views migrant home care workers as temporary labour which is entitled to only elementary rights.[5,26] This further demonstrates the ambivalent and uncertain position of the worker, who is scrutinized for being present as well as for being absent.

Although the roles performed by migrant workers in the hospital are not substantially different from those performed by family members or non-migrant paid workers,[8] the conflicts that emerge are potentially more negative due to the inferior role of these workers in Israel and the perception of these workers as temporary with the sole purpose of providing home care services.[5,26] The fact that Israeli workers provide home care services for only several hours per week, rather than round-the-clock care and are less vulnerable to work-related abuse and exploitation[27] further emphasizes the potentially volatile situation of live-in migrant home care workers within hospitals. Further research will benefit from comparing the experiences of Israeli and migrant home care workers in hospitals.

The introduction of migrant workers into the workforce lowers the wage of competing workers.[28] Although nursing staff and home care workers do not compete for the same position, there is some potential overlap in their roles within hospitals. This could potentially damage the prestige of nursing as a profession. If emotional tasks of caregiving are left at the hands of migrant home care workers, whose work tends to be under-valued, this puts at risk the perceived worth of caring for the elderly.[15] Alternatively, it is possible that by allowing migrant home care workers to undertake less professional tasks, such as bathing, emotional care or monitoring, the status of nursing as a profession will be elevated due to clearer distinctions between the work of carers and of nurses. There is a need to acknowledge and study this caregiving

arrangement and its potential implications to the health care system and to care of the elderly in high-income countries.

Funding

This study was funded by the Israeli Ministry of Health.

References

1. Organization for Economic Cooperation and Development (OECD). *Health at a glance 2011: OECD indicators*. OECD Publishing. http://www.oecd.org/els/health-systems/49105858.pdf (2011, accessed 19 March 2015).
2. Israel Medical Association. *Position paper: the physicians shortage in Israel*. Israeli Medical Association. http://www.ima.org.il/ENG/ViewCategory.aspx?CategoryId=6152 (2011, accessed 19 March 2015).
3. Heller E. *The treatment of older adults in Israel. The topic of foreign homecare workers in Israel and Israeli nursing care workers–needs and available solutions* [in Hebrew]. Jerusalem, Israel: Haknesset: Research and Information Center, 2003.
4. National Insurance Institute of Israel. *Annual review: long term care community law* [in Hebrew]. Jerusalem: National Insurance Institute of Israel, 2011.
5. Ayalon L. Evaluating the working conditions and exposure to abuse of Filipino home care workers in Israel: characteristics and clinical correlates. *Int Psychoger* 2009; 21: 40–49.
6. Walsh K and O'Shea E. Marginalised care: migrant workers caring for older people in Ireland. *J Popul Ageing* 2010; 3: 17–37.
7. Huang S, Yeoh BSA and Toyota M. Caring for the elderly: the embodied labour of migrant care workers in Singapore. *Global Networks* 2012; 12: 195–215.
8. Auslander GK. Family caregivers of hospitalized adults in Israel: a point-prevalence survey and exploration of tasks and motives. *Res Nurs Health* 2011; 34: 204–217.
9. Cho S-H and Kim H-R. Family and paid caregivers of hospitalized patients in Korea. *J Clin Nurs* 2006; 15: 946–953.
10. Li H. Hospitalized elders and family caregivers: a typology of family worry. *J Clin Nurs* 2005; 14: 3–8.
11. Levine C and Zuckerman C. Hands on/hands off: why health care professionals depend on families but keep them at arm's length. *J Law Med Ethics* 2000; 28: 5–18.
12. Ayalon L, Halevy-Levin S, Ben-Yizhak Z, et al. Family caregiving at the intersection of private care by migrant home care workers and public care by nursing staff. *Int Psychoger* 2013; 25: 1463–1473.
13. Iecovich E, Rabin B and Penchak M. Tasks performed by migrant live-in care workers during hospitalization of their older care recipients. *Home Health Care Serv Q* 2013; 32: 178–196.
14. McCluskey A. Paid attendant carers hold important and unexpected roles which contribute to the lives of people with brain injury. *Brain Inj* 2000; 14: 943–957.
15. Ayalon L. Family and family-like interactions in households with round-the-clock paid foreign carers in Israel. *Ageing & Society* 2009; 29: 671–686.
16. Fouka G, Plakas S, Papageorgiou D, et al. The increase in illegal private duty nurses in public Greek hospitals. *J Nurs Manag* 2012; 21(4): 633–637.
17. Patton M. *Purposeful sampling*. *Qualitative evaluation and research methods*. Newbury Park, CA: Sage Publications, Inc., 1990.
18. Strauss A and Corbin J. *Basics of qualitative research techniques and procedures for developing grounded theory*. 2nd ed. London, UK: Sage Publication, 1998.
19. Creswell JW. *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, CA: Sage, 1998.
20. Lorenzo FME, Galvez-Tan J, Icamina K, et al. Nurse migration from a source country perspective: Philippine country case study. *Health Serv Res* 2007; 42: 1406–1418.
21. Groutsis D. Recruiting migrant nurses to fill the gaps: the contribution of migrant women in the nursing care sector in Greece. *J Int Migrat Integrat/Revue de l'integration et de la migration internationale* 2009; 10: 49–65.
22. Kline DS. Push and pull factors in international nurse migration. *J Nurs Scholar* 2003; 35: 107–111.
23. Mitchell K, Marston SA and Katz C. Introduction: life's work: an introduction, review and critique. *Antipode* 2003; 35: 415–442.
24. Ayalon L. Family and family-like interactions in households with round-the-clock paid foreign carers in Israel. *Ageing Soc* 2009; 29: 671–686.
25. Ehrenreich B and Hochschild AR. *Global woman: nannies, maids, and sex workers in the new economy*. New York, NY: Metropolitan Books, 2000.
26. Ayalon L, Kaniel M and Rosenberg L. Social workers' perspectives on care arrangements between vulnerable elders and foreign home care workers: lessons from Israeli/Filipino caregiving arrangements. *Home Health Care Serv Q* 2008; 27: 121–142.
27. Green O and Ayalon L. Violations of workers' rights and exposure to work-related abuse of migrant live-in and Israeli live-out home care workers: a preliminary report. Under review.
28. Borjas GJ. The labour demand curve is downward sloping: reexamining the impact of immigration on the labour market. *National Bureau of Economic Research*. http://www.nber.org/papers/w9755.pdf (2003, accessed 19 March 2015).