CASE REPORT

Elderly care between global and local services: the use of somatic care practices

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SUMMARY

Israel's population is ageing alongside the worldwide ageing population. As the population ages and the number of older people who are 'ageing in place' increases, the system of elderly care will face new opportunities and challenges in responding to non-institutional services for elderly care. There is an increasing demand for foreign caregivers despite differences in language and cultural background. This case report describes the global care services provided in Israel by caregivers from the Philippines to emphasis the cultural and social components of elderly care. The following case analyses the use of somatic care practices as culturally intuitive sensitivity practices adjustable to the local culture, especially since the caregiver from the Philippines and her Israeli patient do not share a common language or cultural background.

CASE PRESENTATION

A 72-year-old Jewish widowed mother of five children emigrated from Morocco and settled in Israel. She was cared for by a caregiver, a 40-year-old married woman and a mother of three children in the Philippines. The patient's children requested that the placement agency search for 'A good Filipina caregiver' since they opposed the idea of admitting their mother to a nursing institution. 'A nursing institution located in another city is a foreign place; I could not imagine my mother there, sharing a room with complete strangers when she is not used to travelling from her neighbourhood by herself. She was always either with my father, before he passed away or with one of us' said the patient's son. However, when I asked him about the idea of a foreign Filipina woman in his mother's home, he replied: 'this is different because my mother is still at her home, near us and next to her familial neighbourhood, and we know from the agency that the Filipina woman is a very good, adjustable and attentive caregiver, if she lives at our home she will not be a foreigner'.

The son's explanation represents how the Filipina dominance of the Israeli caregiver market was constructed and coded especially for them by the placement agencies. In this way, her foreignness is characterised by the qualities of being good and attentive. A 'Filipina' has even become the generic term for an in-home, female non-professional caregiver despite the fact that the Israeli patient and the Filipina caretaker do not share a common language or cultural background.

After 2 months of waiting, caregiver came to Israel and, after 2 days, was assigned to the patient. At first, it was like a 'blind-date', where nothing, including language and cultural background was shared. They had little verbal communication because caregiver spoke no Hebrew or Arabic and the patient spoke no English or Tagalog. However, over time, based on day-to-day practices and interactions, they become familiar and relatively close, despite the fact that they still did not speak the same language. The patient was cared by the caregiver from 2002 until the patient passed away in December 2004.

When the patient was asked to explain her medical condition, she would usually describe it as 'something sweet that eats my body'. The patient suffered from diabetes, which caused loss of vision and pain in her legs.

On the morning of Sunday, February 2004, I entered the patient's house, and saw the patient lying in her bed and caregiver sitting next to her, holding her hand. They were still both dressed in pyjamas. The patient's three floor house was narrow, thus they were unable to get their two beds into one bedroom. Although caregiver had her own room, she put her bed next to the patient's bed in the living room in order to see her and immediately attend to her needs.

Caregiver whispered to me: "During the night, she was in pain, but the pills were not effective. I gave her a little glass of *Arak* [Mediterranean alcoholic liquor]." The patient opened her eyes and moaned quietly. Caregiver touched the patient's face slowly and gently, while holding her hand, until the patient's eyes closed again and she fell asleep.

After 10 min, caregiver released the patient's hand and went into the kitchen to prepare breakfast. Half an hour later, caregiver woke the patient up, calling her "*Ima* [Mother in Hebrew], wake-up, you need to eat". The patient opened her eyes, moaned, and caregiver lifted her over some pillows and began to feed her spoon after spoon. Unexpectedly, the patient closed her eyes and bit her lips in pain. Caregiver held her hand, telling her in Hebrew again "*Ima* [Mother], I am here". The patient's voiceless tears began to fall. She held caregivers hand and told her in Arabic, "*T'iech binti* [Thanks, my daughter]." Caregiver relaxed the patient by touching her face, reorganising the pillows and helped her lie back.

GLOBAL HEALTH PROBLEM LIST

- Global elderly care services and their application on a local level
- Cultural and linguistic barriers

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- Somatic and culturally intuitive sensitivity care practices
- Filipina caretaker ability
- Elderly care policy
- Ageing in place

GLOBAL HEALTH PROBLEM ANALYSIS

Overview

Israel's population is ageing alongside the worldwide ageing population. In 2013, there were 750 000 people aged 65 years and older (9.9% of the total population), and it is estimated that 1 650 000 will be aged 65 years and older by 2035. At 81.5 years, Israel's average life expectancy is ranked sixth place worldwide (the average age for women is 83.5 years and for men is 79.7 years). As the population ages and the number of older people who are 'ageing in place' increases, the system of elderly care will face new opportunities and challenges in responding to this population's desires and needs. 'Ageing in place' is a term that refers to individuals growing old comfortably and safely in their own homes, neighbourhoods and communities, at the municipal level.[1]

The ageing population will generate an increasing demand for caregivers, a demand made challenging because of the declining availability of native-born caregivers. These complex changes are leading to increased employment of migrant or foreign-born care workers. Healthcare institutions and long-term care facilities have been turning to the foreign born to address shortages of workers, reflecting a parallel trend in the migration of healthcare workers worldwide. This case report describes the global care service provided in Israel by caretakers from the Philippines.

In Israel, the caregivers from the Philippines (Filipinas) are mainly young, female, non-Jewish and non-citizen temporary workers employed as live-in caregivers for the country's aged, sick and dying citizens. The option of recruiting Filipina caregivers is delivered through local placement agencies as one of the National Social Security system services available for elderly care in Israel.

On the basis of the Israeli Nursing Care Law of 1988, Israeli citizens who cannot care for themselves in at least oneof five activities of daily living in an index of bodily practices—eating, dressing, walking, bathing or controlling urine or bowel movements—are considered in need of a permanent daily attendant, partially paid for by state funds. This care can be obtained either in a nursing institution or by home care assistance from migrant caregivers, most of whom have migrated from the Philippines (today it is also possible to recruit foreign caregivers from Nepal, India and Romania).

Since the 1990s, the option of importing Filipina caregivers has been outsourced by local placement agencies. These agencies have become active participants in the privatisation of Israel's migrant labour market.[2] Following a shortage of manual labourers in the agricultural and construction sectors during the mid-1990s, Israel became host to large numbers of non-Jewish foreign workers, primarily from Asia and Eastern Europe.[3] These workers were originally assigned to replace Palestinian workers from the occupied territories who, after the outbreak of the first Intifada in 1987, were repeatedly prevented from entering Israel. In this context, the elderly care sector developed as an unintended consequence of the agencies' domination in the migrant labour field. However, today, the elderly care sector has expanded, becoming the prime organised sector for recruiting in-home foreign caregivers.

However, the outflow of caregivers from the Philippines to Israel not only meets Israel's local need for elderly care, but is also part of a growing globalised economy of domestic services. Female caregivers from the Philippines are employed worldwide as caretakers for young, healthy children and families or as housecleaners (cf in Malaysia see ref 4; in Kuwait see ref 5: in Los Angeles and Rome see ref 6; in Hong Kong see ref 7 and in Taiwan see ref 8), transforming the Philippines into the contemporary modern 'empire of care').[9]

In Israel, female migrant worker from the Philippines are known as 'Filipina'. A 'Filipina' has become the Hebrew generic term used to describe the employment category of in-home, female non-professional caregivers who perform 'bodywork'.[10] They work according to contracts, which define their temporary and low-paying conditions. The term 'Filipina' in Hebrew reflects the Philippines as the caregivers' country of origin, as if the ability to provide care is part of Filipinas' natural makeup. This term is based on the cultivated reputation of the Filipinas as maternal caregivers, which has actively promoted their export in the global market for domestic, geriatric and family care service.

However, in contrast to their worldwide tasks, in Israel, only working with patients known in Hebrew as *se'udi* is considered legal. The Hebrew term *se'udi* refers to a patient whose dependent condition requires the attendance of a caregiver to support in meeting the requirements of basic bodily functions. In contrast with the visually or physically challenged, who are defined according to a physical absence, the "*se'udi*" patient is defined as such due to the necessity of his or her dependence on the care provided by the caregiver.[11]

The case analysis

The content of the daily care between the patient and caregiver is embedded in bodily actions that are carried out repeatedly. This case was selected because its daily treatment variation was observable. As the patient's physical situation declined and her range of bodily movements narrowed, she became increasingly dependent on caregivers care practices. Caregiver fed, touched, held and bathed the patient with intuitive sensitivity. The untrained Filipina used her hands as the most useful and sensual tools of apprehension and of action. There was intelligible communication between them through somatic practices as a tool of communication. Within their hushed intervals, silences and fragments of words in three different languages, conversation and discourse did not become major tools of communication.

In this situation, given the lack of verbal and cultural basis between the Filipina caregiver and her Israeli patient, the hand becomes a social instrument for somatic communication, and can be put to use intersubjectively. On the basis of the phenomenology, the anthropologist Csords defines somatic modes of attention as "culturally elaborated ways of attending to and with one's body in surroundings that include the embodied presence of others".[12] Embodiment in that sense requires that the body (healthy or ill) be understood as socially informed and grounded in culture. The embodied experience refers to the human engagement in the world, so attending to one's body can tell us about its surrounding, that is, attending to bodily forms (aged, disable, fat or thin) or to bodily movement (dancing, walking) or bodily progress (pregnant, sick) is a somatic mode of attention to the position and movement of others' bodies in the social world. This attention has cultural and social components.

These somatic practices are crucial tools used to communicate and to treat pain, especially since the Filipina caregiver and her Israeli patient do not share a common language or cultural background. As described above, the patient and caregiver used a few words in three languages—Hebrew, English and Arabic—but these were not enough for a correct and complete

conversation. At the beginning, those words were meaningless. However, they became gradually loaded with significance not through their translation but rather through the somatic care practices that accompanied them. These practices attend to the body, with the body providing social meaning and interaction. These somatic practices, which acknowledge intuition and sensitivity as essential aspects of patient care, decompose the clear-cut categories of patient and caregiver into coherent joined elements, which are even reflected in kinship terms, namely 'mother' and 'daughter'. The ways in which the care practices are physically put together, the relative proximity between the two bodies, the setting of the two beds, the touching of the face, the holding of hands while dressed in pyjamas and the use of familiarity, are manifested through somatic practices.

When the patient suffered from pain, any touch provided her with a social connection. Her pain had become a mode for social interaction with caregiver, who instinctively responded to it through her hands. Through handholding, as a somatic practice, they both shared the 'here and now' pain experience, and by doing so, they both participated in temporal and spatial immediacy with the same object of attention. The interaction is marked, then, by the handholding, which creates relatively static, corporeal dimensions of intersubjectivity and sensual continuity. This somatic practice appears as the most immediate practice even before talking, creating at first a more intimate, corporeal basis of mutual involvement.

The patient's pain becomes a measure for the intensity of the practices. Caregiver responded to the patient's pain by employing a variety of practices that do not treat or cure but show awareness, intentionality and emotion towards the painful state. Also, the use of *Arak* exemplifies the cultural sensitivity of caregiver, since it is considered as a method of pain relief among Moroccan Jews in Israel. Although some kinds of treatment are not medically proven to be effective, the difference that is made to the state of pain is the intentionality; the deliberation of the social touch through which aged people experience their condition of being attached. Caregiver, as an untrained home caregiver, used her sensitivity and self-consideration to treat the patient, without any previous knowledge.

Most of the Filipina work is performed not as professional medical nurses. This emphasises the globalisation of domestic and healthcare service from the Philippines and illustrates how the feminisation of care is based on the stereotypical notion of women as maternal, sensitive and deprofessionalised caregivers. On arrival in Israel, these women receive a few hours of training at the placement agencies before beginning their work with their patients. Occasionally, they receive further instruction from physicians and nurses of the health maintenance organisation. Most of the Filipinas' job description consists of providing basic care such as preparing meals, feeding, bathing, walking, dressing, assisting with personal hygiene, changing diapers or taking care of toileting and cleaning the house. However, over time and in tandem with the patient's deterioration they perform more responsibilities involving para-professional medical skills including dispensing medicine, installing bags to feeding tubes or connecting the patient to a dialysis machine.

On the one hand, the Filipina must develop culturally intuitive sensitivity (eg, understanding facial and body language, illness behaviours and gender attitudes) rapidly while caring for the patient's body; a body she learns to know better than the patient's own children do. As a result, she will be aware of any deteriorating change in the body, which could be a matter of life and death. On the other hand, the Filipina's culturally intuitive abilities, which can be lifesaving, are not professionally acknowledged or compensated by the placement agencies or the medical establishment on par with Israeli caregivers. Thus, from a bureaucratic point of view, any Filipina can be repeatedly replaced by subsequent Filipina women.

Although Filipina caregivers occupying the lowest ladder in the formal employment nursing structure, at the homes of their patients they have become exclusive, skilful and authorised caregivers. Over time, Filipina foreign homecare has emerged as a socially acceptable solution and a respected standard of care chosen by Israeli families to age in place.

Learning points

- As the population ages and the number of older people who are 'ageing in place' increases, the system of elderly care will face increasing demand for foreign homecare.
- Somatic care practices can be considered as crucial cultural tools used to communicate when the patient and the caretaker do not share a common language or cultural background.
- In order to adjust to the local culture, facial and body language, illness behaviours and gender attitudes are culturally intuitive sensitivity skills that a migrant caretaker should develop.
- Employment policies may need to seek the improvement of jobs in the elderly care sector either through training, regulations on earnings and working conditions or by other means.

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