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Integration of foreign-born nurses in Finnish social and health care organizations: Evidences, challenges and responses

This paper explores cultural diversity issues in Finnish social and health care organizations by looking at the experiences of foreign-born nurses (FBNs) and employers and considering how the regulation framework shapes the position of FBNs in the Finnish labour market. The results from the fieldwork reveal that nurses' national and professional backgrounds are key in the integration process and that there are differences between 'well-established' and 'new' FBNs. In particular, nurses recruited internationally in recent last years were notably in lower status positions. An explanation is that these nurses were hired to solve a personnel shortage and not because of their qualifications.

Keywords: foreign-born nurse; Finland, integration, cultural diversity, diversity management

1 Introduction

The increasing global shortage and inequitable distribution of health professionals driven by demographic and epidemiologic changes intensifies the demand for health workers globally. The European Commission for example, has estimated a shortfall of around one million healthcare workers by 2020, 600,000 of them in nursing (European Commission, 2012)[1]. On the other hand, several governmental initiatives in the poorest countries have been established to facilitate the international migration of health professionals, especially addressing nurses. Private nursing schools and recruitment agencies for example have flourished to 'produce' and 'export' nurses – e.g. in the Philippines and India – contribuiting to generate explotative situations for these workers (Walton-Roberts, 2015).

The increasing reliance of richer countries on overseas-trained health professionals – i.e. through international recruitment - to address labour shortages has also created culturally diverse workforces as never before. Diversity is indeed expected to increase and become more complex, also because cross-border migration is today less rooted in geographical and historical ties than it used to be (Connell, 2010: 121). This article is concerned with the challenges brought about by such greater and more complex migration of nurses. The focus is on the integration experiences of foreign-born nurses (FBNs) and challenges caused by the increasing cultural diversity in Finnish social and health care organizations. In particular, this article aims to answers the following questions: What is the situation of FBNs in the Finnish labour market and what are

[1] See http://ec.europa.eu/health/workforce/docs/staff_working_doc_healthcare_workforce_en.pdf

their actual integration experiences in social and health care organizations? What is the role of diversity management in the integration of FBNs?

The term 'integration' refers here to the relationship between FBNs and the receiving organizations and societies. It is seen as a two-way process in which structural and individual characteristics are equally important in shaping the integration process and its outcomes in several aspects of social and working life (Spencer, 2011). Firstly, in the host society, there are structural factors such as immigration rules, licensing rules for the nursing profession and labour market practices. A set of problems concerns the recognition of competences and skills that FBNs have acquired abroad, which may increase their vulnerability in the labour market and result in professional hurdles and deskilling. Patterns of deskilling, for example the utilization of FBNs in the private sector rather than in more 'secure' public sector, have been widely reported for instance in the UK and in Spain (see Meardi, Lozano & Artiles 2011; Calenda, 2014). These problems have also been recognized in Finland (Kuusio, Lämsä, Aalto, Manderbacka, Keskimäki, & Elovainio, 2014; Pitkänen, 2011) and other Scandinavian countries (Widding Isaksen, 2012).

Another set of problems concerns socio-cultural aspects such as inadequate language proficiency of FBNs, prejudices and discrimination at the workplace, and conflicting interpretations of roles and tasks based on diverse nurses' cultural backgrounds. Recent studies conducted in Finland suggest that these are common problems experienced by FBNs, in spite of the increasing international standardization of nursing education and practices (e.g. Vartiainen et al., 2016; Vartiainen, et al., 2017).

Further, the availability – or absence – of measures relating to diversity, equality and non-discrimination in employment and workplaces are important factors for integration. In recent decades, the management of cultural diversity has been conceptualized as a strategy to promote working practices, behaviours and orientations that positively recognize diversity and enhance the motivation and performance of the personnel as a whole (Roosevelt, 1991). In particular, diversity management is seen as a means to integrate minority personnel in the work organization. The basis for inclusive, sustainable management that is fair to everyone lies in legislation or/and voluntary initiatives indicating discernible relations between equality, anti-discrimination, human rights and corporate social responsibility. Accordingly, organizations that adopt effective diversity policies modify their management strategies and practices in which a proactive Human Resources (HR) function (recruitment, training and development, performance appraisal, incentives) has a main role in embracing diversity (Sippola, 2007).

In the following section the Finnish context for nurses' migration is discussed. Then diversity management is introduced and conceptualized as a means to foster smooth–running everyday work. The fourth section presents the research strategy and in the following sections the empirical findings of two fieldworks in Finland are presented and discussed.

2. The Finnish context for nurse migration

Inward migration to Finland has been relatively small in scale for historical and geographical reasons. The cold climate and a language commonly considered difficult have caused Finland to be a not particularly attractive destination for migrants. For instance, when other Western European countries, from the 1950s to the 1970s, attracted labour from abroad to their factories and later into the service sector, Finland was a rather closed society and not particularly welcoming towards foreign arrivals. Labour shortages were mainly filled with internal migration – i.e. domestic population moving from the rural areas to the urban areas (Korpela, Rantanen, Hyytiä, Pitkänen, & Raunio, 2014: 81-83). Nevertheless, since the 1990s, the relative number of foreign arrivals has increased in Finland more rapidly than in any other Western European state (Lepola, 2000: 23-24). The numbers have increased especially rapidly in the capital area, where about half of all foreign residents are currently settled. In most cases newcomers move from Russia or Estonia but in recent years, migration from other EU countries, from the Middle East and the South-East Asia has also increased.

An issue of current concern in Finland is that the baby boomer generations born after World War II are approaching the age of retirement. This generational shift is taking place in Finland earlier than in other European countries. [2]. In fact, Finland is in a rather difficult position concerning population ageing compared to other EU and OECD countries. It has one of the highest old-age dependency ratios, one of the highest shares of population aged over 65 years (20 per cent of the total) and the highest share in the EU of people reporting long-term illnesses. These factors explain an anticipated increase of 5 per cent in the social expenditure share of GDP (from 25 per cent in 2001 to 30 per cent in 2030).

It is expected that in 2030 the death rate of Finns will be higher than the birth state and that the proportion of retired population will grow rapidly in Finland. This means that the number of people in need of social and health care will increase in the future. Already now, lack of workforce is a real problem in many social and health care organizations, especially in the eastern and northern parts of Finland. The ageing population means that there are demands for labour, which are difficult to meet without work-related migration and international recruitment of workers.

2.1 Migration policy in Finland

In 2006 the Finnish government established the *Government Migration Policy Programme* (still operational) which seeks to actively promote labour migration to Finland. The programme emphasizes both the utilizing the existing overseas-trained labour force and developing a policy on work-related immigration. Further, the

[2] Data reported in this paragraph were retrieved from Eurostat and in particular from 'Population structure and ageing' and 'Healthcare personnel statistics - nursing and caring professionals' (http://ec.europa.eu/eurostat/); and from OECD Health Statistics 2014 (http://www.oecd.org/els/health-systems/oecd-health-statistics-2014-frequently-requested-data.htm).

politics of difference have been introduced in the programme. The goal is to promote the development of a pluralistic, multicultural and non-discriminatory society. In order to lay down guidelines for Finnish migration policy in the long term, the *Future of Migration 2020 Strategy* was adopted in 2013 in the form of a government resolution. The strategy highlights that labour migration should be promoted "developing estimation of work force needs and readiness for allocated recruiting abroad" (Government Resolution on the Future of Migration 2020 Strategy, 2013: 13).

To prevent discrimination in Finnish society and work organizations, a *Non-Discrimination Act* (1325/2014), initially passed in 2004, was amended in 2015. The amended act expands the obligation to promote equality not only in public administration but also in the private sector. Employers employing at least 30 persons are obliged to draw up a plan to promote equality and non-discrimination.

Measures to deal with cultural diversity have also been launched in the social and health care sectors. The National Advisory Board on Social Welfare and Health Care Ethics published in 2004 a report entitled Multiculturalism in Finnish Health Care (ETENE, 2005), in which multiculturalism is presented as part of the strategy aimed at preparing work communities to operate with increasingly diverse personnel. International recruitment has recently been addressed by a campaign Developing Fair Recruitment Practices[3] launched in 2014 by the Finnish Institute of Occupational Health. The campaign calls for the national legislation to adapt to international regulations and standards regarding fair recruitment practices (EU directives and ILO policies). This initiative highlights the concept of cultural diversity and encourages approaches to 'sustaining diverse talent' through actions such as mentorship and training in intercultural communication and diversity management.

In spite of the pluralistic goals of the equality initiatives mentioned above, policy attempts have had limited practical effects and administrative as well as managerial practices have often been rather assimilationist in nature (Pitkänen, 2011; Sippola, 2007). In addition, concerns regarding the widespread occurrence of anti-immigrant sentiment have emerged associated with the unfavourable economic situation experienced by Finland in recent years. Such sentiments have gained momentum when the populist and nationalist-oriented Finns Party (previously known as the True Finns) has augmented significantly its governmental influence.

2.2. Current trends in the nursing workforce

There are three different health care systems in Finland: municipal health care, private health care and occupational health care systems. The largest share of health services is provided by municipal health care, reflecting the predominant role of the public sector as well as a decentralization reform started in the 1990s.

[3] More information is available at: http://www.ttl.fi/en/changing_work_life/immigrants_and_work/employment/recruiting_diverse_personnel/pages/default.aspx [accessed 10 June 2015].

As far as the nursing profession is concerned, there is a clear social and wage hierarchy from top to bottom as follows: registered nurse, practical nurse and nursing assistant. Registered nurses are responsible for administering medication and the overall planning of care, practical nurses mainly support patients in their daily activities, while the third personnel group consists of nursing assistants tasked with assisting support functions such as feeding and cleaning. Unlike in the cases of nurses and practical nurses, there is no formal education for nursing assistants, and the profession is not regulated.

Overall, the Finnish health care system offers relatively good quality health services at a reasonable cost with fairly high user satisfaction. In 2012 the density of nurses per 1,000 population in Finland was 14.1, which is much higher than the OECD average (9.1). Finland also scores well in terms of nursing graduates: in 2013 they were 68.9 per 100,000 population (OECD average: 46). Despite this result, the inequitable distribution of health professionals and especially personnel shortages in rural areas and small municipalities is considered a problem. As stated above, Finland is challenged by current and anticipated shortages of caregiving personnel, especially in elderly care, which has opened routes for the international recruitment of nurses.

The number of foreign-born health care personnel has increased in Finland. According to the figures provided by the Health Care Assistants Expert Network and Database (2005), while in 2000 there were 1,450 nurses and 2,285 practical nurses of foreign background working in Finland, by 2012 the respective numbers had increased to 3,442 and 6,602. At the end of 2010, 2.8 per cent (2,805) of nurses working in Finland were non-native (TSR, 2015). Table 1 presents the countries of origin among foreign-born health care personnel.

TABLE 1 Countries/regions of origin of foreign-born health personnel in Finland (2012)

Origin country/ region	Sweden (%)	Estonia (%)	Other EU countries (%)	European non-EU countries (%)	Russia (%)	Asia (%)	Africa (%)	America (%)	Other (%)	Total (%)
Physicians	8,3	17,8	20,0	3,4	34,9	8,1	3,6	2,8	1,1	100
Nurses (incl. midwifes)	30,0	9,6	10,0	3,5	15,7	9,6	17,4	3,0	1,2	100
Practical nurses	20,4	10,3	6,2	5,2	20,5	18,0	14,9	2,7	1,8	100

Source: TSR, 2015

Traditionally the inflows of nurses into Finland have followed migration patterns connected to the country's geographical and historical ties (e.g. with Sweden[4], Estonia and Russia) and, most recently facilitated by the EU enlargements. Only recently Finnish social and health care organizations have started to actively recruit

[4] In the case of nurses from Sweden, many of them are people of Finnish origin whose parents moved to Sweden during the period 1960-1970.

nurses from abroad, particularly from the Philippines and Spain. Around 300 nurses have been recruited from the Philippines since 2008, and about 150 from Spain since 2012.

The typical entrance jobs for foreign-born nurses (FBNs) in Finland are as practical nurses or nursing assistants in hospitals, health centres or elderly care homes. The criteria for licensing as nurses depend on where the applicants have received their qualifications – in a Nordic country, another EU country, the European Economic Area (EEA) or outside the EU/EEA. The Finnish licensing authority, the National Supervisory Authority for Welfare and Health (Valvira), requires health care professionals to have an adequate professional and linguistic skills and knowledge for performing their tasks. While a language certificate is not required from EU citizens to process the licensing, third-country nationals are required to hold a certificate of satisfactory Finnish or Swedish language skills[5]. Further compensatory measures may also be required from third-country nationals to obtain a licence and include an 'aptitude test' and an 'adaptation period'. The aptitude test measures general nursing skills, and the adaptation period is the period of time one needs to work under the supervision of a senior nurse, which may not exceed three years.

3. Management of diversity as a means to foster smooth–running everyday work

In addition to difficulties faced by FBNs in getting their skills and competences fully recognized, their integration into the Finnish social and health care organization also depends on how the receiving organizations address the increasing cultural diversity among personnel. It is not only the foreign newcomers who should adapt but the whole personnel need to learn how to interact and work constructively together. In the interests of equality, fairness and the well-being of the entire personnel, it is also necessary to have un-biased management and human resource management (HRM) practices that are capable of adapting to the increasingly diverse work environments.

This section addresses questions about how to pave the way for smooth every-day work, tackle power structures and promote ethnic minorities' equal opportunities and treatment in the work community. Smooth-running daily work and successful work outcomes are dependent on both individual factors (e.g. employees' skills and working attitudes) and organizational factors (e.g. how the work is designed and organized) (Engeström, 1987). In practice, many work communities are operating systems built on the dominant educational, cultural and professional expectations. According to Janssens and Zanoni (2014) this calls for broader norms in cultural identities and competences, and 'normalize diversity' by destabilizing the dominant hierarchical system of binaries such as: skilled vs. unskilled, productive vs. unproductive, valuable vs. valueless and so on.

5 Available at: http://www.valvira.fi/documents/18508/85975/working_as_a_registered_nurse.pdf [accessed 10 Apr. 2015].

It has been argued that HRM systems are often culturally biased, supporting and valuing the skills and the qualities of the majority (e.g. Sippola, 2007; Cox, 1993). Culturally-based assumptions and prejudices may put all kinds of minorities in an unequal position because the operating system and its structure support standardized measures and homogeneity, which is no longer working 'properly' because not all employees fit in with their qualities and characteristics (Sippola, 2007). For example, the focus is often only on the lack of proficiency in the dominant language, argued to be the main cause of unsuccessful work outcome and inter-group conflicts. This is a common issue when looking at the situation in Finland, and especially the case of FBNs (Pitkänen, 2011; Sippola, 2007).

Culturally diverse organizations can be categorized according to their strategic responses to issues of equality and diversity in relation to the structural and informal integration of diverse personnel (e.g. Cox, 1993; Thomas & Ely, 2001). The most advanced diversity management approaches (see Thomas & Ely, 2001) stress pluralism: equal and fair treatment of everyone, implying that there is no need for 'specific support' for minorities. Indeed, the general tendency in theoretical discussion on diversity management is today towards so-called 'inclusive multiculturalism' and mutual integration (Van der Zeen & Otten, 2015; Stevens, Plaut & Sanchez-Burks, 2008). This includes notions that "people from different groups possess different perspectives and skills, which are valuable resources for organizational learning" requiring that the well-being and inclusion of all will be recognized and "a smooth and efficient functioning of diverse work teams" will be taken into account (Otten & Jansen, 2015: 77-80).

Therefore, to manage cultural diversity in social and health care organizations, it is crucial to widen the spectrum of a capable overseas-trained health care professional and acknowledge as equally valuable the needs, rights and capabilities of the entire personnel. This all implies that the above-mentioned binaries as opposite views should be replaced and the demands of all employees should be considered *normal*, not specifically "ascribed to their specific ethnic background", and not only seen from the perspectives of the majority/dominant demands and values (Janssens & Zanoni, 2014: 328).

To overcome the binaries, and to identify the strategic issues in (effectively) managing cultural diversity, two *structural equality markers* can be identified (Janssens & Zanoni, 2014), namely (1) the valuing of multiple forms of knowledge, skills and competences; and (2) the enabling of all employees to express their identities. The use of such markers is appropriate when there is a need to assess ethnic equality and "when there is a large gap in formal qualifications between the ethnic majority and the ethnic minority" (Janssens & Zanoni, 2014: 329). Such a situation often applies in the case of FBNs in Finland. It is thus crucial to identify the equality markers as critical factors and consider whether their application can contribute to better management of diversity and integration of FBNs.

4. Data and methods

The investigation of the integration experiences of FBNs was based on data collected in spring 2014 in five Finnish social and health care organizations as a part of a research project entitled 'Increasing intercultural understanding in work communities: Contextual action research in social and health care work' (MULTI-TRAIN)[6]. Additional data on the experiences of FBNs and managers were gathered in spring 2015 in a large multicultural public hospital and in a private elderly care home located in the metropolitan area of Finland (see Calenda, 2016).

In both fieldwork periods a qualitative research approach was used, which made it easier to collect sensitive information, such as experiences of discrimination at the workplace. Key informants – FBNs and their managers – were interviewed in semi-structured interviews to reconstruct and talk about the interviewees' experiences and approaches to cultural diversity and professional integration as well as the daily interaction and intercultural work experiences.

The respondents for the MULTI-TRAIN study were selected with the help of expert teams (with 5-7 members) set up in each participating work organization. The expert teams included HR personnel, Finnish and foreign nurses, physicians and supervisors. The interviews conducted with foreign-born nurses were used for the study presented here. Additional data was collected in 2015 through focus group interviews with managers of one of the biggest Finnish public hospitals and regional and local managers of one of the biggest Finnish private healthcare organizations. In both cases the interviews were conducted in Helsinki (for more details see Calenda, 2016). In the private health care facility – namely an elderly care home – the managers allowed the researcher to meet and interview the FBNs available on the day of the interview (two Spanish and two Filipino nurses).

Altogether 45 semi-structured interviews were conducted by the authors and other researchers of the MULTI-TRAIN project in social and health care organizations (five public and one private) in the southern and western parts of Finland. The FBNs interviewed (n=33) differed in occupation, country of origin, age and gender (see Table 2). Four practical nurses were interviewed twice, in spring 2014 and spring 2015. The managers interviewed (n=8) were working in public hospitals (n=6) and in private elderly care homes (n=2). The managers included persons in key roles such as the Human Resource Manager; the Customer Service Director, Nursing Directors, and so on. The languages used in interviews were Finnish, English and Spanish; translation was not needed except in the case of three Spanish respondents.

Table 2. Characteristics of the FBNs interviewed

[6] MULTI-TRAIN (www.uta.fi/multitrain) was conducted in 2013-2017 in five social and health care organizations in different parts of Finland. A total of 127 Finnish and foreign health professional was interviewed for the study.The aim of the study was to generate understanding of the ways in which work communities can adapt, in a sustainable way, into increasing cultural diversity and to produce mutually agreeable transformative actions.

Summary of FBNs interviewed	Respondents (=33)
Country of origin, more than one respondents	Estonian 10, Spanish 7, Filipino 6, Congolese 2 (n=25)
Country of origin, one respondent each	Bangladeshi 1, Burmese 1, Ethiopian 1, Iranian 1, Nigerian 1, Portuguese 1, Russian 1, Ukrainian 1 (n=8)
Gender	20 females, 13 males
Age	21 – 62 years
Occupation	14 practical nurses, 13 nurses, 6 nursing assistants

All interviews were recorded, transcribed (verbatim) and analysed using qualitative content analysis. In the next section the analysis of the key findings mainly concentrates on the experiences of the Estonian, Spanish and Filipino nurses. These are prominent as most of the interviews focused on these national groups, thus yielding richer data for empirical analysis.

5. Findings

Estonian nurses: examples of successful integration paths

The findings reveal that integration into the Finnish work organizations is easier to Estonian nurses than those coming from other countries, especially from Africa and Asia but also from Spain. Slightly similar languages and geographical proximity facilitated the integration of Estonians. The Estonian interviewees (10) had migrated to Finland on their own, mostly pushed by economic factors (by wage differentials) although familiar reasons were also mentioned as important factors. At the time of the interviews, four out of ten Estonians worked as nurses, five as practical nurses and one as a nursing assistant. Although the majority had obtained their qualifications in Estonia (only four had graduated as nurses in Finland) only in two cases had they initially worked in entrance jobs in Finland (a practical nurse worked as a cleaner and a nurse as a practical nurse) and they reported having accepted those jobs in order to learn Finnish. No Estonian interviewees were able to speak fluent Finnish on arrival but they reported having learned Finnish fairly easily.

Similarly, their integration into Finnish society turned out to be relatively smooth since their arrival in the country: most of the Estonians interviewed had Finnish friends and cultivated hobbies in Finland, most of them kept company with their Finnish colleagues during their leisure time, and some of them were married to Finns. Their integration seemed to be fairly successful and the interviewees felt that they were equal

members of the work community. Some of them were active in trade unions (one even in a commission of trust) and one practical nurse acted as a tutor for Spanish nurses. As the result, all the Estonian interviewees reported a clear intention to stay permanently in Finland.

Some Estonian interviewees made a clear distinction between themselves and other foreigners ("they"). Some criticism was also voiced by Estonians towards their foreign colleagues. Statements like "Foreigners are unclean"; "Spanish nurses are slow"; "Filipinos come to Finland only to earn and send money back home" were reported by several interviewees. Some even mentioned that they hoped that not too many foreigners would come to Finland. These views may be explained by the fact that Estonian nurses, together with Russians, represent the most numerous and well-established groups of migrants in Finland, which may give rise to defensive attitudes towards 'new' migrants who may be perceived as competitors.

Spanish nurses: risks of professional demotivation

All the Spanish interviewees (7) were qualified nurses in their home country and had been recruited internationally. They all had taken part in pre-departure training in Spain before departure. Unemployment in Spain and the search for adventure were the main reasons for them to move to Finland. At the time of the interviews, four out of the seven respondents worked in Finland as practical nurses in a private sector organization and three were working as nurses in public sector organizations. They all had been living in Finland for only 1-2 years.

Among the Spanish interviewees, we found a clear difference in terms of job satisfaction between respondents working as nurses and those working as practical nurses, the latter being clearly less satisfied than the former. Some of them expressed clear frustration with their jobs. One practical nurse said: "At the moment we are dealing with such tasks which can be done in Spain without any qualification". Some interviewees complained that in Finland nurses have to do tasks such as washing patients in elderly care homes, which in Spain are done by assisting staff.

Learning Finnish turned out to be a key obstacle for the integration of the Spanish nurses, in spite the fact that they had taken part in 2-3 months pre-departure training, including Finnish language courses. Most of them had also received help from their work communities concerning language skills. The lack of proficiency in Finnish language limited the nurses' chances of getting their professional competences recognized by their colleagues. Their ability to take part in the everyday activities such as participating in team meetings where problem areas were discussed and decisions concerning work tasks and schedule were taken, was also contingent upon their language skills. A sense of exclusion resulted also in situations where they did not understand the written rules and procedures or documents circulated in the workplace. One interviewee argued that "...these documents should at least be translated into English for those like us who are not still able to master technical language".

Two Spanish nurses reported that their knowledge of Finnish had improved since their arrival, they managed

to carry out their tasks autonomously and had quite fluent interactions with their colleagues. Nevertheless, the nurses reported being not able to communicate entirely autonomously with patients and, most importantly, felt limitations in expressing their professional competence with colleagues. This seemed to be a source of frustration that in some cases was amplified by deskilling. One Spanish interviewee argued: "Finnish colleagues and to some extent Estonian nurses tend to treat us as if we were of a lower professional status, and this just happens because we cannot fully express ourselves in their language!".

Unexpectedly, among the Spain nurses, some practical nurses reported slightly better experiences and opinions about their work and social integration than did their nurse colleagues. This result may be influenced by the fact that all the practical nurses interviewed, although not fully satisfied with their current job situation, lived in Helsinki, whereas most of nurse respondents lived and worked in small to medium-sized towns. Among these nurses, feelings of a lack of social connections and isolation were often reported during the interviews. Some of them wanted to move to the metropolitan area in the hope of improving the quality of their social and working lives, whereas others reported a clear intention to leave Finland within one or two years.

Filipino nurses: 'trapped' at the bottom?

The Filipino interviewees (6) were working in both the public and private sectors. Their integration experiences were rather similar to those of the Spanish respondents. With the exception of one respondent, who had been living in Finland for 16 years and was married to a Finn and able to speak Finnish quite well, the lack of proficiency in Finnish was considered to be the main obstacle to both professional and social integration. Learning Finnish had turned out to be much harder than they initially thought, although they benefitted from pre-departure language training (typically for four months) in the Philippines and from extra language courses upon their arrival in Finland.

The Filipino nurses interviewed worked mostly as practical nurses in elderly care homes. They liked their work although they were aware of doing jobs for which they were overqualified. The work with old people was something the interviewees reported in positive terms, reflecting the Philippine tradition of taking care of elder family members. In fact this is an aspect that was commonly considered a 'good' characteristic of Filipino nurses by both recruiters and employers when recruiting nurses internationally to fill staff shortages in elderly care homes. However, and beyond good individual skills, such a 'family' touch with which Filipino nurses treat patients might also generate conflicting interpretations of the role and tasks of nursing professionals. A managerial representative of the department of orthopedics involved in the focus group reported that Filipino nurses "treat patients with too much compassion and they do everything for them".In Finland a common goal in elderly care is to help old people to be as independent as possible. This appeared to be rather difficult for many Filipinos. A Filipino (male) interviewee said:

> My perception is that there's really a difference because when I do the helping the asukas (inhabitant), do their things like sometimes asukas don't have the energy to do (…) they

> cannot eat, I try to feed them but the perception of my co-worker is that it's not right. That it is not the right thing to do because the asukas, she will be dependent on you.

The managers: 'one-way' integration logic

Conflicting interpretations of the roles and tasks of nursing staff appeared encompassing various culturally-based aspects such as leadership and the ability of the nurse to take autonomous initiatives. In the opinion of one manager of a public hospital, the Filipino nurses were not active enough in taking initiatives:

> They are used to wait for commands from their superiors and less likely to take initiatives compared with what we use to do here. Even after few years they have been here, there are still conserving their habitus. It is about a culture of care rooted in social and historical contexts, and it can take long for them to adapt to our way.

According to one manager in the private sector, a key challenge for the integration of FBNs was their dependence on others and the lack of self-direction, which resulted in inability to take responsibility. This interviewee was, however, aware that not all FBNs are similar; the manager emphasized that it is important to know about the backgrounds and circumstances from which the overseas workers have come.

Although the potentials of FBNs were highly appreciated by some supervisors and some managers stressed developing new ways of working, it emerged from the interviews that the mindset of most managers concerning foreign workers' socialization to their new work environments reflected a one-way integration logic: adaptation was seen entirely as a task of FBNs. Notions of threat and fear of 'otherness' or bringing along new 'strange own habits' were recognized in each organization.

In all the organizations studied, we perceived a tendency to see 'Finnishness' as the norm. This was apparent both in the ways the nursing profession was understood and how a well-functioning work community was understood. Statements like "learning by doing is embedded in Finnish culture" and it is "our way to do things" were common among the managers interviewed. Such statements were rooted in the belief that Finland has "one of the best health care systems in the world" and that "Finnish education guarantees the know-how".

A general conception among managers was that professional overseas nurses should act like Finnish nurses, and that their own cultural identity issues, such as religious demands mainly belong to their leisure time. Conversely, some FBNs expressed their wish to contribute more to the work environment through showing what they really can do and bringing what they really are, indicating a high consideration of their own professional identity and cultural habits. It is noteworthy that almost all the FBNs interviewed reported a sense of belonging to the work community, which was perceived as a "big family". Most of them said that they could exert influence on the work schedules and arrangements and make suggestions about how to perform the work. The relationships with co-workers turned out to be good overall.

In some organizations a need to create a more inclusive management system was acknowledged. One manager mentioned that although until recently their workforce has been culturally homogenous, changes would be needed in the near future, such as implementing specific initiatives to meet the challenges posed by the international recruitment of nurses. The manager highlighted the role of mentors (or supervisors, typically senior nurses) as key to the integration of recently arrived FBNs:

> The way mentorship of foreign nurses has been carried out until now may need to be rethought and the challenges that have emerged since we have recruited nurses from far away should be considered more carefully.

6. Conclusion

Until recently the presence of nurses with diverse national backgrounds in Finland was mainly due to the inflow of nurses coming from adjacent countries such as Estonia and people born abroad but trained as nurses in Finland. Such a situation reflects the slow but progressive increase of cultural diversity in Finnish society. Overall, these health professionals, culturally and professionally, seem to have adapted to Finland fairly smoothly.

Less smooth seems to be the adaptation of foreign-born nurses from countries without historical ties with Finland. This seems to be the case of the Spanish and Filipino nurses that Finnish social and health care organizations have started to recruit in the last decade. For these nurses adaptation problems at the workplace originate firstly from insufficient language skills. Despite the pre-departure training organized in the source country, deficient Finnish language skills turned out to be an obstacle to the professional and social integration of Filipino and Spanish nurses. In addition to mistakes and misunderstandings caused by the deficiency of language skills, different conceptions about how to treat patients and relatives were common experiences among the nurse and manager interviewees. In spite of this, most FBNs did not want to bother their Finnish colleagues by asking for advice. For example, interviewees of African and Asian origin especially reported avoiding asking their colleagues to assist them or correct their language because they did not want to bother them. Most FBNs were also reluctant to describe their own capabilities or to fully use their professional skills or knowledge, probably because of language problems.

Other work integration challenges emerged from the interviews are rooted in the diversity of nursing practices, which can be a cause of conflicting interpretation of roles and tasks. Additionally, concerns about the professional (re) socialization of these nurses in the Finnish context intertwine with aspects of sectorial and professional regulation – e.g. licencing rules - that seem to not facilitate the social mobility of FBNs, especially for those coming from outside the EU. In particular, the Filipino and Spanish nurses interviewed during the fieldwork were found to be in lower status positions and had to start their careers in jobs for which they were overqualified. In most cases these nurses had failed to find employment commensurate with their qualifications. An obvious explanation is that they were hired to solve the shortage and turnover of mainstream personnel, not because of their qualifications. This tendency of FBNs to concentrate in entrance

jobs has been observed in other migrants receiving countries – e.g. the UK– and seems to reflect the prevalent modes of restructuring of long-term care for older people in many richer countries (Ruhs & Anderson, 2010).

The role of managers and supervisors turned out to be crucial in the professional integration of FBNs. It also became evident that in order to support the professional integration of all FBNs, the role of diversity management needs to be strengthened. In the study conducted, it was assumed that making improvements in the integration of FBNs would be feasible by recognizing the existing power structures (see Janssens & Zanoni, 2014). For that purpose two equality markers were used to analyse and discuss the empirical findings. The findings show that in terms of the equality marker one, *valuing of capabilities*, the work outcome and technical skills of FBNs were good according to the managers. On the other hand, from the point of view of the marker two, *enabling to express one's identity*, there appeared to be a strong tendency to suppress the cultural identity of FBNs beyond their professional identity.

The markers helped us to reveal why the qualifications of foreign-born nurses are not fully used and that FBNs may find themselves in disadvantaged positions – in spite of minority and majority employees having similar educational profiles. In most cases the integration of FBNs seemed to be connected to the ways cultural diversity was managed in the everyday work. Equal and fair treatment and freedom to express one's own identity and demands are a part of good management.

All in all, the findings demonstrate a need to broaden the norms on both competences and identities of all employees when assessing and designing sustainable, ethical and effective management of diversity. Instead of targeting a change in the cognitions and behaviours of FBNs there is a need to pay attention to an organization's ability to change. A process of two-way cultural adaptation is necessary not only for the integration of FBNs in the Finnish social and health care organizations but also to ensure successful intercultural collaboration and efficiency at work.

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