VERSITA

Special Issue Article • DOI: 10.2478/v10202-012-0018-4 NJMR • 3(2) • 2013 • 82-90

Nordic Journal of Migration Research

"DOES SHE SPEAK NORWEGIAN?"

Ethnic dimensions of hierarchy in Norwegian health care workplaces

Abstract

This article highlights implications of two aspects of glocalisation – migration and New Public Management – at different levels in the Norwegian health care sector. They meet in the concept of competence, the central principle of hierarchisation in this sector. 'Norwegianness' emerges as an important informal competency, while there is a need for allowing the conceptual alignment of 'migrancy' with medical competence. Most immigrants who are not able to align themselves with 'Norwegianness' hit what Nirmal Puwar calls the 'concrete ceiling of race', while a few manage to find jobs further up through assimilating into pre-existing schemas of 'Norwegianness'. This may lead to a loss of competencies useful in a diverse society. In the absence of political will to counteract this tendency, it is likely to cause growing inefficiency in the sector.

Keywords

migration • new public management • competence • nursing homes • hospitals

Received 1 September 2012; Accepted 11 April 2013

Rannveig Dahle[1*], Marie Louise Seeberg[2]

[1]Norwegian Institute of Social Research NOVA,
[2]Norwegian Institute of Social Research NOVA

1 Introduction

Ajaya[1] is head of department at an Oslo nursing home. Born and educated as a nurse in India, she immigrated to Norway as a young woman and has specialised in geriatrics and psychiatry. She has been co-operating with researchers like us for more than a decade, sharing her experiences with an aim to improve conditions for people from immigrant background in Oslo. She has often experienced discrimination and exclusion. The following is a glimpse from an occasion where this happened, at an event where one of the authors of this article was present:

> A seminar was held at a research institute to present the results from a research project. The institute's Director opened the event, held exclusively in Norwegian, and the next speaker was a Director General from a government ministry. Three leaders from the health care sector in Oslo were invited to comment after the project leader's presentation. Ajaya was scheduled to be the first of these three. Before the seminar started, a researcher introduced Ajaya to one of the Directors present, emphasising her central role as a research facilitator. The Director listened to this, looked at Ajaya, hesitated, and turned to the researcher with the question: 'Does she speak Norwegian?' The researcher assured him that yes, Ajaya did indeed speak Norwegian. Only then did the Director shake Ajaya by the hand and say he was pleased to meet her. Standing nearby, I could see that Ajaya was upset, and, as we found our seats, she confirmed this: 'I am used to that kind of comment, but I had not expected it from a person in such a high position', she explained.

The Director's evident disorientation led him to disregard Ajaya, asking others about her competence in her presence, as if she were not there. For her, this amounted to a peak in cumulative experiences of misrecognition of herself as a competent person. 'I am used to that kind of comment', she said. What produces the repetitive pattern of confusion and rudeness that Ajaya reports? With this question as a point of departure, we explore some of the implications of a changing ethnic composition of staff along with a keen focus on competency management in an increasingly glocalised health care sector in Norway. We regard migration and New Public Management (NPM) as two aspects of glocalisation (see Näre 2013a), both strongly felt in the Norwegian health care sector, and our focus is on some implications of their combined manifestation at different levels in this sector. They especially meet in the concept of competence, which is the central principle of hierarchisation in this sector as well as being a core theme in NPM (Hood & Lodge 2004). We shall explore the questioning of Ajaya's competence – in a context to which she had been invited as a particularly competent person – as an incident occurring at the intersection of migration and NPM.

* E-mail: rda@nova.no

The postcolonial feminist theorist Nirmal Puwar shows in her book 'Space invaders: Race, gender and bodies out of place' (2004) how implicit, normative processes in institutions may lead to a prescription of who is regarded as naturally belonging in the spaces they occupy, and who is viewed as disruptive in their positioning, as 'space invaders'. While they are indisputably there, 'they still do not have an undisputed right to occupy the space' (Puwar 2004: 1), thus typically producing processes of disorientation. As a leader, Ajaya takes up a privileged position which is conceptually 'reserved' for 'Norwegians'. She has repeatedly felt what it is like to create disorientation through her very presence as a manager and leader 'rather than as service staff' (Puwar 2004: 42), a presence that interrupts a racialised episteme and thus disturbs a taken-for-granted order. Investigating moments of disorientation may thus expose otherwise implicit, historically embedded power structures. Through highlighting the particular, the event described above thus throws light on the structural conditions which formed this event.

We therefore ask: How is 'Norwegianness' or a lack thereof interpreted, symbolised and enacted as an implicit premise for competence in the health care sector and what difference does it make? We perceive the health care sector as a hierarchical setting that we connote with the descriptive term 'pyramid' to capture its unequal cultural dynamics. Historically, the professional groups were neatly separated along lines of gender and social class. Male medical doctors, most of them recruited from the upper-middle classes, formed the apex of the pyramid; female auxiliary nurses from working-class backgrounds were located at the bottom, with nurses, mostly female and from middle-class backgrounds, in between. 'Norwegianness' as it has emerged as a new cultural divide in the age of globalisation lacks stable configurations and meanings. Our ambition is not to define the term, but to explore some of the instabilities and point to their empirical implications. Three aspects of 'Norwegianness', all closely related to ideas of competence and competency management, are under scrutiny:

- Professional: different institutional and hierarchical locations, that is, the bottom and top of the structural pyramid of health care. Who typically works where, and how are people categorised?

- Practical: the role of knowledge and competence within the system, highlighted through asking: What counts as knowledge, also on a symbolic level, in and between separate levels in this sector?

- Symbolic: the role of language in patient-related work and in communication between colleagues in everyday practices, not just as an instrument of communication in a semantic sense, but as a symbol of the right kind of competence that legitimises the occupation of differently valued positions.

We return to these three aspects of 'Norwegianness' when we discuss our findings. First, let us present some salient features of the sector where we undertook our research.

1.1 Background: the Norwegian health care sector

The Norwegian health care sector has undergone a number of major changes during the past decades, simultaneously incorporating the effects of global migration and the spread of NPM (Seeberg 2007).

Although Norway was never the homogeneous society that national myth would have it (Kjeldstadli 2003, 2005), this hegemonic myth is now challenged by the immigration of people from far and near. The health care sector has seen a larger increase in staff 'from immigrant background' than most other sectors.

Health care providers from immigrant background are unequally distributed in the structural pyramid of health care institutions (Roksvaag & Texmon 2012). In nursing homes, there is an increasing ratio of workers without formally recognised health care competence. This is especially so in the Oslo area where, coincidentally, the population has a higher proportion of people from immigrant background[2] than any other part of Norway (Roksvaag & Texmon 2012).

The wide category of 'staff from immigrant background' includes two quite different subcategories in terms of competence. The largest group consists of men and women who have lived in Norway for a number of years and have found their way into this sector largely because other work is harder to get. Almost half of the 'immigrant background staff' are classified by their employers as 'unskilled'[3] and, importantly, receive much lower salaries than their 'skilled' colleagues, most of whom are auxiliary nurses. That is, they are employed and paid as 'unskilled' workers, although they may well have qualifications that are not deemed relevant to their jobs: their 'cultural capital' is not readily convertible to 'economic capital' (Bourdieu 1986). Another large group consists of qualified health workers who migrate to Norway in order to find work in their field of expertise. Their competence is evaluated on an individual level as they apply for authorisation to work within their professions, and they are usually required to take additional courses or training before they are authorised.

According to one report, employees from immigrant background account for 10% of work (counted by hours of work) on nursing level and higher, and over a third of medical doctors. These numbers include immigrants to Norway from all countries (Aamodt et al. 2011: 47).[4]

Changing conceptions regarding the organisation of health care, new medical technologies, and the implementation of NPM, widely understood as a globalised transfer of private sector management ideas to the public sector, have all led to profound changes in the last few decades. In Norway, there have been a series of reforms since the early 1980s, and the speed of change seems to be increasing. In 2001, hospitals became organised as state-owned enterprises and administered through four regional enterprises comprising all hospitals, with little or no external transparency in governing procedures.

Nursing homes are the responsibility of local municipalities. Most of them are run by municipalities, while a few are contracted out to NGOs or private enterprises. In nursing homes, whether private or municipal, NPM provides the general governance principles. The impact, however, is different from that in hospitals, as nursing homes are historically embedded in local political practices.

Somatic hospitals constitute the apex of a long-established pyramidal hierarchy in the health care sector, while nursing homes are located at the bottom. Competence is the principal value ranking the elements of this hierarchy and as we shall see, the meaning of competence is not static but context dependent and adaptable. There are striking differences between top and bottom in terms of power, prestige and influence, as well as in terms of economy, organisation and political governance. This overarching hierarchy is replicated in each workplace.

The sector employs a series of different occupational groups which work together and separately. Nurses constitute the largest

profession with 35% of all registered health care workers, with auxiliary nurses at 28% and medical doctors at 10% (Roksvaag & Texmon 2012). The statistics accounting for the share of 'unskilled' workers in the sector are incomplete, but one estimate is 30% of the total (Econ 2009).

Nursing remains a 'female profession' with 95% women; among auxiliary nurses the female proportion is even higher (Roksvaag & Texmon 2012). However, women now constitute a majority of the medical students, and the proportion of women in the medical profession will soon exceed 50% (Roksvaag & Texmon 2012). Yet the presence of women in male spaces will not automatically 'feminise' these places (Puwar 2004: 149).

A rapidly growing elderly population challenges the structure and content of the health care system and creates new and different needs for care. Elderly patients occupy an increasing proportion of beds in hospitals (Garåsen et al. 2008), while nursing homes for the elderly represent the largest growth in terms of employment (Roksvaag & Texmon 2012). Recruiting workers with formal qualifications in health care work into the bottom of the pyramid is turning out to be increasingly difficult at a time when the need for such staff has never been greater. Nurses tend to cluster in somatic hospitals where the professional challenges are regarded as greater and providing more professional learning (Vibe & Martinussen 2010). Surveys among student nurses indicate that only 4% have nursing homes as their working preference (Abrahamsen 2011). Young nurses, explaining why they prefer not to work in nursing homes, claim that the managerial work available to them in nursing homes demands more and different knowledge than they possess shortly after they have finished their education (Vibe & Martinussen 2010). They need more experience before taking on heavy responsibilities with few nurse colleagues to rely on in their daily work.

The structural changes simultaneously raise new and different claims on all kinds of health personnel, with a sharpened focus on competency management. Notably, the changes demand extensive communicative skills among staff. The constant flow of reorganisations makes the whole field dynamic, but also continuously more complex. None of the reforms have explicitly dealt with the new ethnic composition of staff and patients within this system.

New constellations of staff in the health care sector reflect and represent wider societal changes and increasing ethnic diversity. 'Newcomers' are more than welcome to the extent that they realise a potential as a flexible recruitment pool in the health care sector. Recruiting specialists from abroad was an explicit public policy in the 1990s, a policy that in the wake of the brain/care drain debate is now considered problematic on ethical grounds (Eastwood et al. 2005; Kenechukwu & Megan 2009; Meyer 2001; Seeberg 2012c; SHD 2007;). With the field left open to other actors, recruitment of nurses from abroad is still a significant part of the picture (Seeberg 2012c). National policies aiming at recruiting and qualifying 'unskilled' residents from migrant backgrounds into the health care sector are still active. Recruiting these men and women into 'unskilled' care work with a view to gradually qualifying as auxiliary nurses is officially regarded as a win-win situation by the Directorate of Health and Social Affairs (SHD 2006). Unemployed or underemployed segments of the immigrant population are thus expected to fill the empty end emptying spaces that constitute the least attractive positions to native Norwegians. The new ethnic composition in the sector has not disrupted the established hierarchy in the health care sector, as the 'immigrant-background workforce' is confined to the lowest level of the pyramid.

1.2 Methodology

This article is based on data and findings from a qualitative study conducted from 2003 to 2005 at a nursing home and a somatic hospital, both located in Oslo. Up to 35 health care workers – of which four were nurses – were employed at the nursing home unit, approximately one third of them full time and the remaining two thirds on different part-time contracts. At the hospital, of around 60 persons employed mainly within the unit where we conducted our study, approximately 35 were nurses and 10 were auxiliary nurses. The main questions under investigation were new challenges and contestations in the working practices and relationships among staff in differently glocalised institutional contexts, with health worker migration and NPM as the two main glocalisation processes that we wanted to study. The interplay of such processes is complex and best studied through an explorative and qualitative research design where categories and categorisations are subject to scrutiny. Although we apply what one might call a 'bottom-up perspective', our main concern is with structural conditions and with the interplay of structure and agency, and not with agency as such.

In the initial phase of our project, we needed to get access to a hospital and a nursing home for our fieldwork and interviews. We had no difficulties in finding a nursing home to study. Contrary to this, applying for access to conduct fieldwork in a somatic hospital resulted in a series of rejections from different hospitals, with a whole range of justifications. It took over a year from our initial request to the first hospital until we were granted access to one single department in another hospital. This happened after persistent informal lobbying via individuals within the system who supported the project, but were not in decision-making positions. As leaders of enterprises detached from political responsibilities, the hospital leaderships were autonomous gatekeepers with the power to accept or refuse research in any part of the hospital. For government institutions, refusing to take part in research funded by the Norwegian Research Council would normally be problematic, but it appears that the NPM creation of hospitals as enterprises – albeit government owned – has changed this. The nursing home at the bottom of the pyramid had not been turned into an enterprise, but was still a public institution, directly accountable to the local government. One may view this initial experience as an indication of our unwittingly being implicated in an on-going process of structuring and maintenance of the hierarchy taking place at the top of the pyramid. This was a demonstration of power since power is, among other things, the ability to draw invisible boundaries and to decide who is to gain access to the elite and who should be denied such access (Solheim 2007).

We conducted fieldwork for nearly six months in each of the two workplaces, mainly in the form of active, participant observation in the staff rooms, supplemented towards the end of the fieldwork with interviews of a selection of staff in each workplace. In the study, we were concerned with structural barriers, collaboration practices in the two departments, the meanings and implications of language differences and other differences deemed to be of importance in the two departments, as well as with how these dimensions are framed by local contexts (Seeberg 2012a, 2012b; Seeberg & Dahle 2005, 2006). In the present article, we focus mainly on the (re)construction of structural pyramids as a form of social hierarchy on the question of knowledge or competence and on the dynamics that shape and reshape practices within such pyramids. Specific ideas of competence and 'competency management' became part of the spread of NPM through the 1980s and 1990s (Horton et al. 2002).

2 The nursing home

We conducted most of the fieldwork in the nursing home in the department where Ajaya was the manager. Nearly all the resident clients were Norwegians, while the care workers constituted a heterogeneous group from various backgrounds. Thirty-six people, born in 15 different countries, regularly worked together in shifts. Four European, five African, and seven Asian countries were represented in the staff, who proudly pointed this out to us. The working language was Norwegian, a rule that Ajaya strictly supervised. The gender composition was unusual in a caring context, as there were 26 women and as many as 10 men among the regular staff. The heterogeneity of the group also included many different motives for working there and a whole range of career plans. To some of them, the nursing home served as a transitional stage while they were waiting for authorisation as nurses or medical doctors, based on education from their countries of origin. Others were university graduates in other fields of study, but had been unable to get jobs according to their educational levels in their fields of education. Some of these were still looking for other options, while some had resigned to the idea that other jobs were beyond reach.

The local authorities in the urban district where the nursing home was located displayed a political consciousness emphasising that a minority perspective mattered in all workplaces in the area. This recognition reflected a relatively high proportion of immigrants in the local population and in the administration. Local political documents recognised the need of greater emphasis on the needs of minorities in local government. This approach was motivated both with ideological concerns and as realism concerning the heterogeneous recruitment pool. Among other things, they practiced a co-ordinated effort against discrimination on ethnic grounds. In the administrative board, there was an earmarked position for the managing of ethnic and other inequality relations, and every workplace in the district had its own equality representative. There was also a system for handling complaints about ethnic discrimination. The staff knew this, and some had made use of it. Despite this organisational model, there were still tensions and challenges in the system.

3 The hospital

The hospital where we finally gained access was a somatic hospital. As such, it was close to the top of the health care pyramid. In contrast to the nursing home's residents, a substantial part of the hospital's patients did come from an immigrant background as the hospital, due to its geographical location in Oslo, served a population with immigrant as well as Norwegian backgrounds. On their Internet pages, the diverse clientele was translated into a description of the 'unique profile' of the hospital as its 'multicultural competence' was marketed to the general public as an important resource and asset. Indeed, some hospital routines were adjusted to meet with different needs. For instance, there was open access for the extended family to visit round the clock and it was accepted to some extent that families brought their own food, while the hospital also offered a limited choice of halal and other options on its menus. The hospital also housed its own interpreter service.

Finding out about the origins of each employee was much more difficult here than at the nursing home. The hospital was much larger, and we had access to just one department. This was also large and with many people working shifts, so we did not get to know all the staff. Further, we discovered that issues of 'migrancy' and related references to ethnic differences (Näre 2013b) within the staff group were largely taboo. As ethnic background or nationality were not registered anywhere, it proved impossible to get a reliable overview of the overall ethnic composition of the hospital staff. We therefore tried to collect useful indicators of immigrant backgrounds. We gained access to a distribution list from the hospital chief executive, composed of about one hundred names. About 5% of the medical doctors on the list had first and last names that indicated immigrant background, although some of them might well have been born in Norway. We also tried to find out whether any nurse from immigrant background had ever held a superior or management position in the hospital, but traced no likely names in the available written texts nor was anyone able to recall such a case. The human resources department was responsible for the handling of job applications and complaints of discrimination. There were no employees in this department with names that indicated immigrant background. Only the kitchen, the service functions and the cleaning departments had a percentage of persons higher than 10% with names of other than recognisably Norwegian origin. We also analysed the shift lists of the personnel working in the one department where we conducted most of the fieldwork. While the overall majority of those in permanent positions carried Norwegian names, most of those who worked in non-fixed positions did not. For what names are worth as indicators of background, then, 'Norwegianness' appeared to be privileged at the hospital.

4 Space invaders and glocalisation

There were striking differences between the various levels in the pyramid regarding the two dimensions of glocalisation in question. The implementation of NPM was the least felt in the nursing home where it was only marginally present in the organisation of work and consistently implemented only in the 'procurement' of, for example, food and equipment. Here, the migration aspect of globalisation was more strongly present in that the staff was predominantly from immigrant background. In the nursing home, ethnicity was explicitly discussed and negotiated among the staff.

At the hospital level, NPM was a structurally dominant feature, while immigrants constituted a minority, who did most of the 'dirty work' (Dahle 2005a; Hughes 1984) as a notable exception. Explicit discussions and verbalised statements on ethnicity focussed exclusively on the patient group. Among staff, being a native Norwegian was taken for granted as the somatic norm and any positive or negative discriminatory practices were either absent or silenced. As Puwar (2004) argues, there is an ontological denial of 'race', gender and class embedded in institutional narratives. The management's lack of attention to ethnic diversity among staff shaped and reshaped a process that silenced all open talk about challenges and new possibilities that come with diversity. The exception was the leader of the in-hospital interpreter services, who was very willing to talk about her frustrations with the hospital's general lack of a multicultural perspective. Her position was organisationally marginal in relation to the wards, her office being a separate unit servicing the whole hospital. As she was also the only person who was employed because of her multicultural competence, she had something of an outsider's perspective on this issue.

4.1 Norwegianness as competence

Knowledge and competence are key features regarding medical treatment and health care, and as social categories they are unequally distributed, valued and ranged. They carry different meanings. Existing competence hierarchies determine what the system recognises as competencies that trig status and salary. Typically, the health care sector draws a major boundary between what is seen as abstract medical knowledge derived from science and practical skills derived from everyday life. This boundary is inherently both gendered and ranged and increasingly also racialised. Knowledge forms associated with medical science, modernity, intervention, social elites, masculinity, rationality and Norwegianness are privileged in the sense that they are typically associated with the most highly valued kinds of knowledge. Various forms of knowledge are given different meanings on a symbolic level and are unequally distributed and ranged (Seeberg 2007). Nurses climb the ladder in the structural pyramid when moving away from low prestige nursing homes to what Waerness (1984) labels 'care of growth' in specialised hospitals. The knowledge forms demanded at the bottom are regarded as merely practical, specific and non-prestigious and left to auxiliary nurses and 'unskilled' staff.

The two institutions and the professionals in this study were ordered by their functions, which again indicated different levels of medical competence. The hospital relied heavily on expert medical knowledge, and was governed by medical logic. The main boundary lines, both in terms of interaction and in mandate, were between those in charge of medical treatment and those in charge of care work. Competence is a key word in ordering the hierarchal levels in the health care sector. But what constitutes competence? Where does an implicit valuing of 'Norwegianness' as a sort of competency trump card come into this larger picture?

Various knowledge dimensions produce mental images that organise the various competences in a hierarchical model. Medical knowledge is normatively marked as expert knowledge; it belongs to the professional elites and is contrasted with lay knowledge. However, medical knowledge alone does not decide how and where the specific individuals and groups fit into the hierarchical system (see also Näre 2013a). Gender, collective or individualist orientation, tradition versus modernity and class are also important dimensions that give legitimacy to certain forms of competence. The dimensions are intertwined in a complex matrix with many layers and levels. The density of medical doctors is high in top-ranked medical institutions while in lower ranked institutions such, as nursing homes, the number of medical doctors is low, rarely more than one, often in a part-time or hour-based position. Expert medical knowledge connotes masculinity while caring work connotes femininity, regardless of the gender of the people actually doing the work (Acker 1992; Dahle 2009). The long-standing efforts of the nursing profession to transform the conceptions of their work from purely practical to being viewed as scholarly, marks a strong ambition to climb upwards on the hierarchical ladder. This process links nursing prestige to high technological medical institutions rather than to nursing homes, where practical care tasks still constitute a main activity.

Through processes of fighting for professional prestige the space at the bottom of the pyramid is left open to care workers without recognised professional competence. Immigrants of all kinds, 'unskilled' – often with skills that they have not been unable to convert on a broader labour market – fill in the available space. As long as these immigrants stay at the bottom, they are not space invaders; rather, they might be regarded 'space saviours' who ensure the continued functioning of an increasingly important part of the welfare state. However, on higher levels, their presence become an invasion of space.

4.2 Norwegianness as a symbol in communication and interaction

At our first meeting in the nursing home, one of the few 'ethnic Norwegians' among the staff pointed out that her colleagues' lack of proficiency in the Norwegian language was at times a problem. As we were later to find out through our observations, this was primarily handled as a practical problem, and solved in pragmatic ways. People found different ways around different instances of the problem. For example, the few who did not write Norwegian well enough to take notes at meetings or write in the patients' journals swapped this task with others, and oral instructions were often repeated in different terms.

This pragmatic attitude to language skills was very different from what we found at the hospital. One incident illustrates this particularly well. Judy was a nurse who had immigrated to Norway from another European country. Although she mastered the technical terminology, she was not a fluent Norwegian speaker. To compensate for her lack of competence regarding language, she made use of gestures and body language to communicate her messages. One day, one of her patients was due to be transferred to a nursing home. The high costs for 'bed blockers' – people whose treatments are completed, but who occupy a hospital bed due to shortage of municipal care alternatives – made quick success necessary. This was Judy's patient; it was Judy's job. One of us was sitting nearby in the office and observed the whole episode:

> *Judy phones the nursing home repeatedly and looks more and more desperate. I understand from what she says, and from supportive but discreet comments her colleagues offer as they pass by, that this is urgent business. Judy is put through from the switchboard to the department every time, but nobody answers the phone at the other end. Each time, she tries to tell the switchboard that they have to find someone she can talk to, that it is urgent and nobody is answering on the department's general line, but with no success. After an hour she is still trying, standing up, red in the face, and one of the auxiliary nurses finally takes over. In fluent Norwegian, she tells the switchboard operator: 'This is very urgent. No, it can't wait. It is extremely important that we get this patient transferred immediately.' It works, and the job is done in less than two minutes.*

Due to her language competence, this auxiliary nurse who herself came from an immigrant background but had grown up in Norway, saved the day. At the same time, she challenged the hierarchical relationship between a nurse and an auxiliary nurse. She amply demonstrated her superiority in mastering a situation that demanded quick action, where Judy had failed completely. Rather than being a practical problem, Judy's lack of 'Norwegianness' became an insurmountable symbolic statement: Judy was unable to do her job.

One of Judy's colleagues, Zola, represents a rather different case. She was a hospital nurse of African origin who had come to Norway as a small child. Her parents were also nurses and had initially been employed by Norwegian missionaries. She spoke the language fluently and mastered all the cultural and linguistic codes, including jokes and body language, often the most subtle

and difficult parts to learn. She commented to us in an interview that mastering the Norwegian language was imperative: 'Norwegians react strongly when there is something they don't understand. In fact, very little is needed before they react negatively', she explained. Zola was accepted and included in her work environment, expressed among other things by the fact that she had been elected a union representative. Although her skin colour was 'a permanent feature of her bodily appearance', she had skilfully 'whitewashed' (Puwar 2004: 150) her tastes and modes of being to the extent not so much of being assimilated, but of showing a will and an ability to assimilate. Zola's ability to adapt to the cultural norm that results from her personal history of extended contact with Norwegian culture also echoes Fanon's argument that 'to speak a language is to take on a world, a culture' (Fanon 2008: 38). As we write, Zola has been promoted to department nurse administrator. Her combined and displayed will and ability to assimilate, to learn and acquire 'Norwegianness', have no doubt continued to be crucial to her success.

In the nursing home, Ajaya, as head of department, contested conventional concepts of knowledge and competence as implicitly 'Norwegian' and used them creatively in new ways. She had experienced the 'concrete ceiling of race' (Puwar 2004: 7) as her applications for higher positions were rejected. As a woman of racialised minority, she had entered a space from which 'women like her' have historically been excluded: she was a 'space invader'. Visibility and support from peers, allies and networks are always crucial for providing opportunities to climb the ladder and applying for new career options. With no such advocacy, she had experienced exclusion through silent and invisible manoeuvres. Despite her obvious capacities as a leader, she had decided to remain on the department in the nursing home without trying move higher up the hierarchical ladder in the Norwegian health sector. She was well aware that many of her staff did not work in the nursing home by choice, and that some of them still aimed for other options. She accepted and supported their endeavours for other trajectories. Equally important, she was able to see and make creative use of the competences they actually possessed, relying on both improvisation and systematic utilisation. There were, for instance, medical doctors and nurses in her staff who were waiting for their licence to practice in Norway. Among many other examples was the IT engineer who did 'unskilled' care work for low pay, but contributed with valuable knowledge to the benefit for the whole department.

Ajaya also encouraged individuals to take more education within caring occupations and to take part in a municipal programme that made it possible to combine work and education. However, she was clear on the point that those without formally recognised medical competence were never allowed to do tasks that demanded such competency, so she kept well within the legal limits of creative management. Her openness and willingness to acknowledge each one for the competences they actually possessed contributed to a positive working environment. Still, it is thought provoking that her staff could not convert their different competences into better pay or status, for example, as employees in fixed, 'skilled' positions. Such conversions were also beyond Ajaya's power.

Language is both a tool and an important symbol in the professional working relationships. For instance, the ability to articulate the 'legitimate' language is essential to coexistence in the professions and is the preserve of those on top of the hierarchy in the sector. 'Sufficient' mastering of the Norwegian language in a caring context not just depends on objective criteria, such as language test results, but as much on structural conditions such as the supply and demand of personnel in the labour market, the organisation of work, and so forth.

It seemed to be a tacit assumption among the native Norwegian providers both in the hospital and in the nursing home that they themselves were more 'naturally' qualified than immigrants, regardless of their actual experience and qualifications. To some extent, this might be justified in that the nursing home had to recruit 'unskilled' workers, some without adequate knowledge of the Norwegian language. Yet, the superiority of 'Norwegianness' was subtly expressed in ways that excluded qualified staff who were perceived to lack this quality, and included 'unskilled' workers from Norwegian background.

4.3 Norwegianness and the structural pyramid

Ajaya told us of several incidents where family members of residents at the nursing home demanded to speak to the manager, even when having been told that she was the manager. On one occasion, one of us witnessed an incident where an employee from a different nursing home proved unable to grasp that Ajaya was, indeed, the department manager. Ajaya was used to ethnic Norwegians being unable to reconcile her as a person with their ideas of a department manager. To them, 'immigrant' and 'department manager' were two separate and conflicting categories, especially as they were positioned at different levels in the hierarchy. This interpretation is supported by the argument that 'Because authority is imagined in gendered and racialised terms, there is an element of surprise associated with seeing people who are assumed to belong elsewhere' (Puwar 2004:144).

5 Ethnic dimensions of hierarchy

It has been argued that there are tendencies towards an ethnically segregated labour market in Norway, in health care as well as in other sectors (Brox 2005). Our material superficially supports this argument. However, a more interesting finding is that such tendencies are not unilinear – on the contrary, there are several tendencies pulling in different directions. For instance, many of the so-called 'unskilled' workers hold competences that are relevant to their jobs. At the apex of the pyramid, such competences remain unseen, while there is more space for alternative definitions of competence lower down and the likelihood of recognising 'other' competencies is larger here. Hence, we argue that the picture is more complex and dynamic than a model of segregation allows for. We also argue that if there, beyond the rhetorical level, is a political will to counteract the tendencies towards segregation, one would do well to direct attention towards the workings of opposing tendencies, in order to plan more successfully for inclusion and anti-discrimination practices for care workers from immigrant backgrounds.

Glocalising processes where global trends result in complex changes in local contexts take place at all levels of the health care sector and will contribute to changes in the composition of staff, competency requirements, and working relations. With these on-going changes in mind, we have tried to identify some of the important driving forces and dynamics that shape the new features and their implications. There is an overall recognition that Norway will need more people in health care work in both the near and the far future than can possibly be recruited domestically, although this is also politically controversial due to problems related to brain drain (Seeberg 2012c). Through such processes of constituting a new labour force, the established hierarchical pyramid is not only destabilised at some points, but also sustained and reshaped through

the new ethnic compositions in the staff, with different manifestations on the various levels in these complex matrices of institutions. On the top level, 'Norwegianness' is implicitly regarded as the norm and taken for granted as a competency in itself, even when medical services are directed at patients from immigrant backgrounds. We found that any 'lack' of 'Norwegianness' in the medical or nursing staff was circumvented and downplayed to the extent of being a topical taboo. Further down in the pyramid, an on-going process of ethnic mixture and negotiation takes place while at the bottom of the pyramid, the number of immigrants is dramatically on the increase, but still taken for granted in a way that reflects the privileged norm of 'Norwegianness' as a competency at the apex.

The article raises a number of new research questions as well as calling for new political solutions in a glocalised care. One question for further exploration is whether the import of immigrant workers will facilitate a process for nurses to transgress their old assistant positions compared to the medical doctors, that is, traditional professional relationships regarding dominance and subordination. If so, the new global work force serves as an unacknowledged precondition for professional upgrading of White Norwegians. These changes take place in a politically and ideologically upgraded sector with many shortcomings, but such premises are rarely made visible and discussed in political terms. An increasingly globalised context moves and challenges the established boundaries between health care professionals. Another finding in the study was that compared to 'Norwegian' providers, immigrants were not regarded as 'naturally' qualified to the same extent, regardless of their actual knowledge and qualifications. This raises the question of the need to redefine competency higher up in the medical system, and for allowing the conceptual alignment of 'migrancy' with medical competence.

As long as there is no shortage of staff in strictly medical institutions, the 'natives' or persons with a high competency in 'Norwegianness' are likely to be the preferred category with opportunities to leave the bottom level of the sector, that is, the nursing homes behind. This indicates that it is the institutional context, rather than the age of the patients, that creates the present hierarchy. Nursing homes are more open to immigrant workers because of the shortage of 'Norwegian' health care workers, who increasingly abandon nursing homes.

The overall number of immigrant workers is likely to increase. This development leaves the structural pyramid almost untouched, with the somatic hospitals still safely positioned at the top and the nursing homes at the bottom. What is changing, as we have seen, is the ethnic composition of the staff at different levels in the pyramid. While we find a vast majority of Norwegian/Scandinavian/West European Whites on the top, workers of other ethnic origin are increasingly filling in at the bottom and some of these are moving upwards. Some, like Ajaya, hit the 'concrete ceiling' as she, despite her versatile competence, lacks the ability to align herself with the dominant cultural norms and is therefore excluded from spaces where 'Norwegianness' is required. Others, such as Zola, manage to secure jobs further up in the pyramid by showing a will and an ability to assimilate into the pre-existing schema of 'Norwegianness'. One side of the effect of such assimilation processes is likely to be the loss of competencies that are useful in an ethnically diverse society, where an increasing number of patients are not originally Norwegian. There seem to be no strong tendencies at present to counteract or bridge the gap or to make innovative use of a variety of competences further up in the pyramid. In the absence of political will to change such tendencies, this is likely to increase inefficiency in the sector.

Rannveig Dahle is research professor emeritus at NOVA (Norwegian Institute of Social Research). She is a sociologist and has particularly published on women's professions and professional work in the health care and social sectors. A recent publication is 'Social work: A history of gender and class in the profession', in *Ephemera, theory & politics in organization* 2012, 12(3): 309–326.

Marie Louise Seeberg is research professor and co-ordinator of migration studies at NOVA. A social anthropologist, she has studied ethnicity and migration in a wide array of contexts. Recent publications include 'Immigrant care workers and Norwegian gender equality: intersections and institutions' in *European Journal of Women's Studies* 2012, 19(2):173–185 and 'Exploring intersectionality, complexity and forms of capital: the case of a Filipino nurse in Norway' in Ragnhild Sollund (ed.) *Transnational Rights, Gender and Migration*: Emerald Group Publishing, 2012, pp. 127–147.

Notes

1 Ajaya has read this text and consented to the way in which her experiences are used as the subject of this article. The name Ajaya is a pseudonym. First names are almost universally used to address people in Norway, so choosing only a first name here does not imply any lack of respect.

2 Definitions of 'immigrants' and related categories are highly politicised and often changed. In this paper, we use the current definition used by Statistics Norway, where an 'immigrant' is a person born abroad to two parents who were both born abroad, whereas a person from an 'immigrant background' is born in Norway to two parents born abroad.

3 In order to draw attention to the problematic categorisation of these employees as 'unskilled', we will use inverted commas around the terms 'skilled' and 'unskilled' in this article.

4 These are high numbers, and we cite them with caution as we have not been able to find other sources to confirm them.

References

Aamodt, PO, Høst, H, Arnesen, CÅ & Næss, T 2011, Evaluering av Kompetanseløftet 2015. Underveisrapport 3 [Evaluation of Competence Reform 2015] NIFU-rapport 1/2011, NIFU Nordisk institutt for studier av innovasjon, forskning og utdanning, Oslo.

Abrahamsen, B 2011, 'Nyutdannete sykepleiere går til eldresektoren [Newly qualified nurses are recruited to care for the elderly]', Sykepleien, vol. 10, pp. 76–77, DOI:10.4220/sykepleienn.2011.0144.

Acker, J 2006, 'Inequality regimes', Gender and Society, vol. 20, no. 4, p. 441.

Bourdieu, P 1986, 'The forms of capital', in Cultural theory: an anthology, eds. T Kaposy & I Szeman, Wiley-Blackwell, Malden. Mass., pp. 81–93.

Brox, O 2005, Arbeidskraftimport: velferdsstatens redning - eller undergang? [Import of labour: the making or the breaking of the welfare state?], Pax, Oslo.

Dahle, R 2005a, 'Dirty work in a Norwegian health context (the case of Norway)', in Dilemmas of care in the Nordic welfare state: continuity and change, eds. HM Dahl, T Rask Eriksen & K Larsen, Ashgate, Aldershot, pp. 101–111.

Dahle, R 2005b, 'Men, bodies and nursing', in Gender, bodies and work, eds. D Morgan, B Brandth & E Kvande, Ashgate, Aldershot, pp. 127–138.

Dahle, R 2009, 'Anerkjennelse, profesjonalisering og kjønn' [recognition, professionalisation and gender], in Kvinners arbeid, eds. L Syltevik & K Christensen, Unipub, Oslo, pp. 83–100.

Eastwood, JB, Conroy, RE, Naicker, S, West, PA, Tutt, RC & Plange-Rhule, J 2005, 'Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK', The Lancet, vol. 365, no. 9474, pp. 1893–1900, DOI:10.1016/S0140-6736(05)66623.

Econ, P 2009, Bemanning i kommunal pleie og omsorg [Staffing in community based carework], 978-82-8232-082-5, Pöyry Management Consulting (Norway), Oslo.

Fanon, F 2008, Black skin, white masks, Grove Press, New York.

Garåsen, H, Magnussen, J, Windspoll, R & Johnsen, R 2008, 'Eldre pasienter i sykehus eller i intermediæravdeling i sykehjem – en kostnadsanalyse' [Elderly patients in hospitals or intermediary nursing home departments – a cost analysis], Tidsskrift for den Norske Legeforening, vol. 128, pp. 283–285.

Hood, C & Lodge, M 2004, 'Competency, bureaucracy, and public management reform: a comparative analysis', Governance, vol. 17, no. 3, pp. 313–333, DOI:10.1111/j.0952-1895.2004.00248.x.

Horton, S, Hondeghem, A & Farnham, D 2002, Competency management in the public sector: European variations on a theme, IOS Press, Amsterdam.

Hughes, EC 1984, The sociological eye: selected papers, Transaction Books, New Brunswick, NJ.

Kenechukwu, A & Megan, L 2009, 'Compensation for the brain drain from developing countries', Lancet, vol. 373, no. 9676, pp. 1665–1666, DOI:10.1016/S0140-6736(09)60927-2.

Kjeldstadli, K 2003, Norsk innvandringshistorie [the history of immigration to Norway], Pax, Oslo.

Kjeldstadli, K 2005, 'Immigration and industrialisation, Norway c. 1840-1949', in Essays on industrialisation in France, Norway and Spain, eds. K Bruland & J-M Olivier, Unipub - Oslo Academic Press, Oslo, pp. 169–182.

Meyer, J-B 2001, 'Network approach versus brain drain: lessons from the diaspora', International Migration, vol. 39, no. 5, pp. 91–110, DOI:10.1111/1468-2435.00173.

Näre, L. 2013a, 'Ideal workers and suspects: employers' politics of recognition and the migrant division of care labour in Finland', Nordic Journal of Migration Research, vol. 3, no.2, DOI: 10.2478/v10202-012-0017-5.

Näre, L 2013b, 'Migrancy, gender and social class in domestic labour and social care in Italy: an intersectional analysis of demand', Journal of Ethnic and Migration Studies, vol. 39, no. 4, pp. 601–623, DOI:10.1080/1369183X.2013.745238.

Puwar, N 2004, Space invaders: race, gender and bodies out of place, Berg, Oxford.

Roksvaag, K & Texmon, I 2012, Arbeidsmarkedet for helse- og sosialpersonell fram mot år 2035 [The labour market for health and social workers towards 2035], SSB, Oslo.

Seeberg, ML 2007, Velferdsstaten møter verden: arbeidsplasser i endring [The welfare state meets the world: changes in the workplace], Gyldendal akademisk, Oslo.

Seeberg, ML 2012a, 'Immigrant careworkers and Norwegian gender equality: institutions, identities, intersections', European Journal of Women's Studies, vol. 19, no. 2, pp. 173–185, DOI:10.1177/1350506811434665.

Seeberg, ML 2012b, 'Intersectionality, complexity, and forms of capital: the case of a Filipino nurse in Norway', in Transnational rights, gender and migration, ed. R Sollund, Emerald Group Publishing, Bingley.

Seeberg, ML 2012c, 'Sykepleiere fra utlandet – fra statlig til privat ansvar? Et kritisk blikk på ordskifte og praksis i norsk rekrutteringspolitikk' [Nurses from abroad – from a State to a private responsibility. A critical look in discourse and practice in Norwegian politics of recruitment], Sykepleien Forskning, vol. 7, no. 2, pp. 134–140, DOI:10.4220/sykepleienf.2012.0081.

Seeberg, ML & Dahle, R 2005, ''Det er kunnskapene mine dere trenger, ikke språket mitt: etnisitet, kjønn og klasse ved to arbeidsplasser i helse- og omsorgssektoren ['You need my knowledge, not my language': ethnicity, gender and class in two healthcare workplaces.], 82-7894-228-5, NOVA, Oslo.

Seeberg, ML & Dahle, R 2006, 'Innvandrede helsearbeidere - og et inkluderende arbeidsliv? [Immigrant health workers - and an inclusive working life?]', in Inkluderende arbeidsliv? Erfaringer og strategier. [An inclusive working life? Experiences and strategies.], eds. T Hammer & E Øverbye, Gyldendal Akademisk, Oslo, pp. 79–102.

SHD 2006, Rapport nr 3. Rekrutteringsplan for helse- og sosialpersonell 2003-2006: rekruttering for betre kvalitet [Recruitment plan for health and social workers 2003-2006: recruitment for improved quality], Sosial- og helsedirektoratet [Directorate of Health and Social Affairs], Oslo.

SHD 2007, Recruitment of Health Workers: Towards Global Solidarity, Sosial- og helsedirektoratet [Directorate of Health and Social Affairs], Oslo.

Solheim, J 2007, Kjønn og modernitet [Gender and modernity], Pax, Oslo.

Vabø, M 2002, 'Kvalitetsretorik i norska kommuner [A rhetoric of quality in Norwegian municipalities]', in Kvalitet utan gränser [Quality without frontiers], eds. E Bejerot & H Hasselbladh, Academia Adacta, Lund, pp. 147–170.

Vabø, M 2012, 'Norwegian home care in transition – heading for accountability, offloading responsibilities', Health and Social Care in the Community, vol. 20, no. 3, pp. 283–291, DOI:0.1111/j.1365-2524.2012.01058.x.

Vibe, O & Martinussen, N 2010, 'Hvordan få sykepleiere til å se på sykehjem som en fremtidig arbeidsplass?' [How to help nurses regard nursing homes as future places of work], Sykepleien, vol. 1, p. 53, DOI:10.4220/sykepleiens.2010.0005.

Wærness, K 1982, Hva innebærer det å ha et kvinneperspektiv på sosialpolitikken? [What does it mean to have a women's perspective on social politics?], Sosialhøgskolen Stavanger, Stavanger.