The Migrant Direct Care Workforce: An International Perspective

By Robyn I. Stone

As the world's developed regions continue to rely on migrant workers from developing countries to fill care gaps, we must embrace international guidelines for workforce hiring and training.

Global aging is one of the most significant demographic trends in history. One in eight individuals worldwide will be ages 65 or older by 2030. And by 2050, 80 percent of the world's 1.5 billion older adults will live in developing regions (Fujisawa and Colombo, 2009). The aging of the world's population is most dramatic for the 85-years-and-older group, those most likely to have physical and cognitive disabilities and to need long-term services and supports (LTSS). This subcategory of elderly individuals is the fastest growing population in Europe, the United States, Canada, and Australia. By 2030, one in four Japanese older adults will be ages 85 or older. In thirty member countries of the Organisation for Economic Cooperation and Development (OECD), one in ten residents will be in the oldest old category by 2050; for the United States, that figure is 7.7 percent.

Of all the implications of global aging, the increased demand for LTSS between now and 2050 has become a priority issue among policy makers, providers, older consumers, and their families in the world's developed and developing regions. Several other trends are raising concerns about the future supply of direct care workers—nursing home assistants, home health and homecare aides, personal care workers—to provide the hands-on care required to meet the increasing demand for services. Projections in Europe, Asia, the United States, and Canada suggest a likely decrease in the availability of family caregivers due to plummeting fertility rates, increases in childlessness rates, increased divorce rates among middle-age and older adults—all factors that lead to less stable and less predictable family caregiving patterns, and greater labor force participation among older and elderly women who were traditional caregivers for adult children or spouses (Colombo et al., 2011; Stone, 2015).

At the same time, a recent OECD report indicates that the size of the working-age population (ages 25 to 64) as a share of the total population is expected to shrink, from 67 percent in 2010 to 58 percent in 2050. The percent

→ABSTRACT One major solution to the projected decline in the availability of direct care workers to provide long-term services and supports is to recruit and rely upon foreign-born or migrant workers. Most workers enter the host country through "unmanaged migration" routes potentially leading to financial, emotional, and physical exploitation of workers, and inadequate education and training that could jeopardize the quality of care delivered, and create significant care gaps in the country of origin. The implications of foreign worker and immigration policy to address the care demands of an aging world should be heeded by all countries. **| key words:** *direct care workers, immigration policy, global aging*

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shrinkage will be less than six percentage points in countries such as the United States, Australia, and Sweden, but more than 15 percentage points in several Eastern European countries and South Korea (Colombo et al., 2011). Furthermore, many women ages 25 to 54—the age group most likely to be employed as direct care workers—will be more highly educated and less likely to be attracted to LTSS jobs.

Policy makers, providers, and consumers already are struggling to recruit a quality, competent direct care workforce to meet current demand for LTSS. The confluence of trends summarized above suggests that the availability of direct care workers is likely to become more challenging in the future. One major solution to this emerging problem is to recruit and rely increasingly upon foreign-born or migrant workers to ameliorate the care gap.

One major solution to a lack of direct care workers is to recruit and rely upon foreign-born or migrant workers to ameliorate the care gap.

This strategy already is in use in a number of developed countries (Redfoot and Houser, 2005; Colombo et al., 2011). Approximately one in five direct care workers in the United States, and one in four direct care workers in Canada and Australia is foreign born (Fujisawa and Colombo, 2009). In European countries as diverse as Germany, Greece, Italy, and the Netherlands, the proportion of direct care workers from other countries is increasing significantly. In the UK, the proportion of foreign-born care workers more than doubled between 2001 and 2009, from 7 percent to 18 percent (Cangiano and Shutes, 2010). In seventeen out of twenty-three European countries involved in the EUROFAMCARE study, family caregivers of older people relied on private migrant care workers at least occasionally (Bednarik, DiSanto, and Leichsenring, 2013).

Even the world's oldest nation, Japan—which historically has been resistant to the use of foreign labor—has begun to explore foreign recruitment as a strategy for addressing the country's widening care gap. The remainder of this article describes the current status of the migrant direct care workforce, strategies countries are using to recruit these workers, and the benefits and challenges of relying upon foreign-born workers, as well as implications for policy and practice.

The Migrant Direct Care Workforce

In most countries, migrant direct care workers, whether employed by private households or by formal care organizations, are predominantly low-paid, middle-age women, with qualifications often higher than is strictly necessary for the job (International Labour Office [ILO], 2013).

Migrant nurses with unrecognized qualifications may end up taking direct care worker jobs, as seen in Canada (ILO, 2013), Spain (Moss, 2006), the UK, and the United States (Redfoot and Houser, 2005). Many foreign-born workers are employed on a part-time basis (Fujisawa and Colombo, 2009). A significant number of foreign-born direct care workers are employed in the informal sector, which includes undeclared or illegal LTSS workers and caregivers receiving some compensation through cash payments or allowances.

There is tremendous variation in countries of origin among the migrant direct care workforce. Geographic proximity to the host country, historical links, and humanitarian migration flows certainly play a critical role in determining migration patterns for many direct care workers (Spencer et al., 2010). In the United States, for example, a majority of migrant direct care workers come from Caribbean countries, Mexico, and the Philippines; foreign-born workers tend to migrate to Canada from the Philippines, other Asian countries, and Sub-Saharan Africa. In the European Union (EU), many foreign workers originate from within the

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EU, mostly from Eastern European countries such as the Czech Republic, Hungary, Poland, Romania, and Slovenia. People from the Philippines, Poland, Nigeria, and Zimbabwe dominate the UK's migrant workforce. Italy draws its migrant workforce primarily from Romania, Ukraine, the Philippines, and Peru (Lamura et al., 2013). Spain's migrant LTSS workforce comes from the Dominican Republic, Morocco, and Peru. Since 2009, Japan has been accepting foreign workers from Indonesia, the Philippines, and Vietnam.

Recruitment Approaches

Recruiting foreign nurses and other more highly skilled professional staff to work in health (and to a lesser extent, LTSS settings) in most developed countries has been achieved through "managed migration schemes," where formal structures have been established between source and destination countries to control the nature and scope of migration flows (Redfoot and Houser, 2005; Fujisawa and Colombo, 2009). This approach is relatively rare when employing migrant direct care workers. One exception is Canada's Live-in Caregiver Program, which allows migrant caregivers admission to the country, provided they fulfill certain criteria prior to and after admission (Spencer et al., 2010). These include evidence of a job confirmation letter and a written contract with the employer, successful completion of an equivalent Canadian secondary school education, at least six months of training or at least one year of full-time paid work experience in the past three years, English or French fluency, and a work permit. Live-in caregivers can later apply to become permanent Canadian residents.

Prior to 2007 in the UK, the immigration channel for direct care workers was used by significant numbers of non-EU social care workers. Since 2007, however, more stringent criteria have been applied, providing limited opportunities to work in front-line caregiving. Senior care worker positions can now only

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qualify for a shortage occupation list for fast-tracked admission if individuals have formal qualifications, two years of certified experience, employment in a supervisory role, and remuneration above a minimum wage threshold. Most observers believe these policy changes have made it very difficult for employers to recruit outside the EU, and for migrant workers to renew their working visas.

Relatively few direct care workers in the United States enter through a managed migration mechanism—a permanent employment EB-3 visa. This visa program primarily is reserved for skilled workers with a bachelor's degree and two years of work experience; lesser-skilled workers can qualify through an "other workers" category. EB-3 visas, however, are capped at just 5,000 workers per year, suggesting that only a few direct care workers are recruited through this route.

In 2008, Japan developed bilateral agreements with Indonesia, conducted language training and basic skills education, and began engaging individuals from this source country into LTSS positions in 2009. More recently, Japan has established similar bilateral agreements with the Philippines and Vietnam. Singapore also has established formal arrangements with the Philippines and Indonesia. In addition, since one of the three major Singaporean populations is of Malaysian origin, many foreign workers from Malaysia cross borders on a daily basis to provide eldercare in this country.

Most of the migrant workers in the LTSS sector in Europe enter through "unmanaged migration" routes, such as overstaying, fraudulent entry, or illegal border crossing (Fujisawa and Colombo, 2009). Some OECD countries (e.g., Austria, Greece, and Italy) rely extensively on foreign-born undocumented LTSS workers. These workers' lengths of stay vary greatly. In Austria, workers from neighboring Eastern European countries usually work on a short-term basis, resulting in high rotation and turnover. Bettio and colleagues (2006) found that many Eastern European women move to Italy for a few months to earn a higher salary and fund a project back home, such as building a house or paying for a child's education. They often return periodically to Italy to work for the same family and may rotate jobs with other workers. Migrants from outside Eastern Europe (e.g., Cape Verde, the Philippines) tend to stay longer.

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It is impossible to predict the impact of the latest major refugee migration from Syria and other countries such as Afghanistan and Iraq, but this huge influx of workers undoubtedly will have some effect on the potential supply of direct care workers. While many individuals in this population are highly skilled, it is likely that most will not be able to practice their professions (e.g., nursing, pharmacy) in the destination countries and initially may either choose a job as a direct care worker or remain in this occupation if career mobility is not possible.

Direct care workers typically enter the United States through family reunification, as refugees, through a green-card lottery, or for unauthorized work (Leutz, 2007). An estimated 79 percent of this foreign-born workforce is legal (Spencer et al., 2010). The vast majority of this legal workforce remains in the United States permanently, and many are naturalized citizens. The recent focus on the "extra-legal" immigrant population in the U.S. presidential election debates raises significant issues for the future of this segment of the direct care workforce. Depending upon the direction that U.S. immigration policy takes in the next few years, it is possible that many of these workers could be deported, leaving a huge gap in this workforce. On the other hand, if these people were granted amnesty, it is possible that they might leave these

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jobs in search of a higher paid occupation in another field, or choose to move into the formal caregiving labor market. These uncertainties underscore the important role that immigration policy plays in the development and sustainability of this workforce.

Benefits of Reliance on Migrant Workers

Among the opportunities offered by migrant work in LTSS, the most compelling are financial (Lamura et al., 2013). At the individual worker level, wage differentials between destination and origin countries represent a strong incentive for migrants, who often remit a consistent part of their earnings to their families left behind. The amount and the magnitude over time of such remittances depend on several factors, including the type of household, educational level, and return plans (Bettin and Lucchetti, 2012).

At the macro level, LTSS staff costs can be kept relatively low through the hiring of migrant workers. This is particularly appealing to families hiring workers on the private market. LTSS organizations also see this as a strategy for managing their budgets. Policy makers struggling with the costs of their public LTSS programs also may view the employment of migrant workers as a way to keep their costs down.

In labor shortage areas, the availability of migrant workers fills a serious care gap. This has certainly been the case in aging European countries and in very old countries such as Japan, wherein the lack of a domestic labor pool has reached crisis levels. In the United States, migrant workers often fill these low-wage positions that their native-born peers are not as interested in pursuing.

For many countries of origin, the remittances sent back to families help to bolster the larger economy. This is particularly true for the Philippines, which is a major supplier of migrant workers across the globe. An estimated $10.5 billion in remittances were sent back to the Philippines from the United States in 2005, with the bulk coming from nurses—the largest service sector–working group of Filipino emigrants (Lorenzo et al., 2007).

Challenges to Reliance on Migrant Workers

While reliance on migrant workers certainly has benefits for individual direct care workers, consumers, families, and origin and destination countries, there also are significant challenges to this approach to developing the LTSS workforce. Perhaps most important is the potential for financial, emotional, and even physical exploitation of workers; because most foreign-born workers are not hired through managed migration schemes, they are paid very low wages, often receive little to no benefits, and have no social protections. For those hired privately, typically there are no job guarantees and little job stability. Given the lack of any formal agreements, there is no oversight infrastructure ensuring the workers are not financially, physically, or emotionally exploited by consumers and family members.

With the exception of a few countries, most migrant workers are not required to have any specific qualifications and training standards, and programs often are minimal. The desire to just hire "warm bodies" to meet increasing LTSS demand raises questions about the quality of care being delivered and the potential to jeopardize the quality of life of elderly consumers.

Many migrant workers do not speak the same language as their elderly care recipients and family members, an issue likely to pose significant communications challenges for consumers and direct care workers. While managed migration schemes tend to require proficiency in the language of the destination country, those hired through informal channels are much more likely to have language difficulties and may or may not receive formal language training while on the job. Cultural differences between direct care workers and older care recipients and family members also may pose significant communication challenges. Differences in communication

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styles (including body language) and perceptions of aging and care (including views of and reactions to dementia, death, and dying) could affect service delivery and create serious relationship problems.

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Finally, the migration of workers to other countries has the potential to create significant care gaps, at individual and societal levels, in their country of origin. Migrant workers often leave children and older family members behind, and while remittances may help financially, those at home may suffer from a lack of nurturing and assistance. Migration of caregivers, particularly those who may have received at least some training in their home country, can create serious skills and knowledge gaps for the country of origin. This is of particular concern because most source countries are in developing regions of the world where the loss of a care workforce can have grave implications for the health and well-being of these countries' populations. Studies examining nurse migration from the Philippines to the United States in the early 2000s indicate that this phenomenon was a factor in a reduced pool of health workers in the home country and was associated with poorer quality of care (Lorenzo et al., 2007).

Conclusion

As global aging increases the demand for direct care workers, it is likely that developed regions of the world will continue to rely on migrant workers, primarily from developing countries, to fill gaps in care. The OECD has developed a set of guidelines to support a quality and ethical process for the international transfer of human capital in the LTSS sector. The first calls for the efficient issue, processing, and delivery of work permits in numbers reflecting care labor needs. Second, tools need to be developed to match migrant workers to care jobs, in both source and destination countries. Third, there needs to be formal channels to verify the trustworthiness of potential employers and employees, perhaps through some type of registry. Fourth, a quality migrant worker program must implement effective workforce enforcement procedures to protect workers, consumers, and employers. As an example of provider support for these guidelines, the International Association of Homes and Services for the Aging—a global organization of aging services providers, and the international arm of LeadingAge—has enthusiastically endorsed these guidelines and has adopted global eldercare workforce development as a priority area.

There also needs to be an investment in the initial and ongoing training of this workforce to address the skills and knowledge that foreign-born direct care workers need to do a quality job. Special attention must be paid to the development of cultural competence on the part of the workers, employers, and consumers. Policies also must focus on fair compensation and benefits to avoid financial exploitation of this workforce and a continued undervaluing of this important and essential occupation.

Finally, the implications of immigration policy for addressing the care demands of population aging across the globe and the development of a viable eldercare workforce should be a priority issue for all countries. Using migrant labor as a solution to the world's eldercare workforce challenges must be considered from the perspectives of fair trade, human rights, quality health and social care, and overall economic development.

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