

The Role of Migrant Care Workers in Ageing Societies: Report on Research Findings in the United Kingdom, Ireland, Canada and the United States

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The Role of Migrant Care Workers in Ageing Societies: Report on Research Findings in the United Kingdom, Ireland, Canada and the United States

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EXECUTIVE SUMMARY

The ageing of the population can present serious challenges to developed Western nations, particularly with respect to the care needed for a growing number of older people. Migrant or foreign-born care workers are increasingly employed as caregivers for older adults, yet little is known about this workforce. This report is a synthesis and comparison of original research carried out during a multi-year project by teams in the United Kingdom, Ireland, Canada and the United States. The research draws insights from secondary data, as well as primary data collected from migrant care workers, care providers, and older adult care users.

From the outset, one commonality observed across all four countries is a relative lack of prioritization of the provision of care for older people. Indeed, most of the central challenges raised by the demand for migrant labour are embedded in the context of an underfunded system of care provision, and an often-underpaid sector of employment. The increasing reliance on migrant care workers is a symptom of those challenges, and migrants, while making important contributions, are not the solution to those deficiencies. Our overarching conclusion is that the major challenges lie, fundamentally, in the reform of the older adult care system to adequately meet the needs of an ageing population.

We found that migrant caregivers already play a substantial role in all four countries and the shift toward older populations, coupled with declining domestic labour supplies, is likely to generate a latent demand for more migrant caregivers. That possibility will likely be bolstered, given recent trends – except perhaps in Ireland – toward the provision of low-wage care in less-regulated areas such as care in home-based settings. Our data show that employer demand for migrant caregivers is shaped by a combination of factors. For example, employers stress the benefits of migrant workers and claim not to pay migrants less than native workers. At the same time, this is overall a low-wage sector which, employers report, fails to attract native-born workers because of low wages and unfavourable employment conditions, and our findings suggest issues relating to migrants' working conditions that need to be addressed. Employers' preferences may be shaped by the perception that their "good work ethic" effectively means that migrants do the job on the employer's terms, that they are willing to work hours and shifts which native-born workers often resist. Furthermore, migrants' loyalty to the organization may, in no small part, be because they are bound to the employer by their immigration status – temporary work visas, in particular, keep migrants tied to their sponsoring employer. We suggest that policies affecting employment conditions for migrant care workers should be prioritized.

With little exception, migrant admission policies in all four countries have tended not to target older adult care workers. Those admitted through labour migration channels for skilled workers have been more prevalent in Ireland and the UK than in the United States or Canada. Only Canada has a temporary admission class for migrants who live in private homes as lesser-skilled social caregivers, but our review suggests it is an exemplar, as well as a caution to expansion of temporary work visas. Indeed, the high percentages of migrants in the lesser-skilled and lower-paid care occupations across all four nations suggest that many enter outside labour migration channels, e.g. in family, student or humanitarian classes. The UK and Ireland receive a substantial supply from new European Union member states, while the United States stands out with about one fifth of its direct/social care workforce being unauthorized. Two things seem clear: the current admission systems in all four nations have supplied substantial numbers of foreign-born workers; and problems with legal temporary work programmes or unauthorized workers signal significant challenges to managing that supply going forward.

While most hiring for in-county migrant caregivers is done through informal means, the use of recruiters is widespread in Ireland and the UK (particularly for overseas nurses) and becoming increasingly important in the United States. Employers turn to recruitment and employment agencies because they can identify skilled workers who are not as tightly integrated into migrant networks and they reduce onerous migration paperwork. On the other hand, the cost of recruiters can be high, thus deterring their use. In all four countries, the use of agencies also raises concerns about unethical recruitment practices.

Once in the workplace, we found that most employers consider migrants to be hard-working and compassionate employees who are reliable and responsible caregivers. The majority of employers suggested that the quality of care had improved through the employment of migrant care workers or had not changed. Employers, caregivers and care users, however, all noted that language and communication issues underscore the challenges of employing migrant caregivers. Knowledge of the English language and the ability to recognize and respond to various dialects, accents and colloquialisms remains the most frequent source of difficulty for all parties, although cultural knowledge and sensitivity in the delivery of care can be obstacles that may persist. In addition, while our data do not provide quantitative evidence of the extent of discrimination in the employment of migrant workers, some migrant workers reported discrimination in relation to wages and working conditions, including the allocation of tasks and shifts, unpaid overtime, opportunities for training and promotion, and disciplinary and dismissal procedures.

Many elderly care users praised the quality of care from their migrant caregivers. Tensions, nevertheless, can exist, in some cases due to language and cultural differences and difficulties in communication, the lack of sufficient time for care workers to develop relationships with older people, or the discriminatory attitudes of some elderly people. Discrimination in this respect can be difficult for employers to address, given their obligations to respond to the preferences of their elderly clients and to ensure the rights of their employees. The importance placed by older people and by migrant workers on their relationships suggests that attention should be given to facilitating those relationships. Attention also needs to be paid to language and cultural sensitivity training, as well as to allowing adequate time for communication between caregivers and care users as central to the quality of care. The goal of person-centred care demands that more attention be given to the education and training of all workers, not just migrant workers.

Our findings lead us to identify policy challenges in four broad domains. First, the migrant care labour market requires attention to recruitment, skill requirements, admissions, mobility, and residency issues. Secondly, the migrant care experience must be addressed in terms of the attitudes and expectations of employers and clients, the training required for foreign-born workers, and the discrimination experienced in some segments of the sector. Employment policies may need to shift to better address the issues unique to migrant workers in the long-term care sector. Thirdly, employment policies may need to seek the improvement of jobs in the sector generally, either through training, regulations on earnings and working conditions, or other means. Finally, there is little evidence that the admission of migrants in long-term care should be a priority, but future employer demand should be closely monitored and migrant admission policies may need reform and better integration with older adult care policymaking.

INTRODUCTION

The ageing of the population presents serious challenges to developed Western nations, particularly those managing the retirement and care of a growing number of older persons. Ageing populations will place demands on expensive retirement and care systems and there will be relatively fewer prime-age workers to meet a range of economic demands. The ageing population will generate an increasing demand for caregivers, a demand made challenging because of the declining availability of native-born caregivers.¹ This problem is compounded by various factors, including, among others, the evolution of today's often-isolated households, declining family care of older people, increasing life expectancy of infirm elderly, and the increasing demand for social caregivers, often in home settings.

These complex changes are leading to increased employment of migrant or foreign-born care workers.² Health-care institutions and long-term care facilities have been turning to the foreign born to address shortages of workers, reflecting a parallel trend in the migration of health-care workers worldwide. Indeed, migrants already play a significant role in the care of older persons in each of the nations studied here and there are many commonalities in the benefits and challenges of that workforce. The use of foreign-born caregivers in long-term care facilities and in homes has broad implications for their recruitment, retention and working conditions. It also affects older clients, the quality of care they receive, and the environment of health-care facilities. The increasing demand for and employment of foreign-born workers, in turn, calls for better-informed immigration and regulatory policies. There are, indeed, many lessons that can be learned for improving the quality of migrants' role in the care of older persons.

This report is a synthesis and comparison of original research carried out during a multi-year project from 2007 to 2009 by independent but collaborating teams in the United Kingdom, Ireland, Canada and the United States. The authors have a special interest in the contributions of migrant caregivers to the older adult care workforce in each of the four countries. The nations studied here are certainly not unique insofar as there are many other nations with ageing populations, but they also differ with the experience of each nation being shaped by their historical, institutional, funding, and social contexts. While paying special attention to national differences, we were also struck by the many commonalities of experiences. From the outset, one commonality observed across all nations is a relative lack of prioritization for the policies affecting care of older persons. There is also (with notable exceptions) little study of caregivers in the sector and practically none on the specific sector of employment for migrant caregivers. In this context, this research intends to open a window on migrants' role in the care of older persons, as well as to generate questions for further research.

Terminology

Employers surveyed in Canada, the UK, and the United States were asked to regard *migrants* as people who were born abroad, while Irish employers were asked to refer to their *foreign-national* workforce. Most migrants interviewed in the UK, Ireland and Canada had recently entered the countries (e.g. in the last decade). However, the vast majority of care workers interviewed in Canada and the United States were either citizens or permanent residents, while the majority in the UK and Ireland were foreign nationals with immigration statuses limiting their entitlements to reside and work in the country.

The questions that these efforts have explored and that form the backbone of this report include:

- the contextual factors influencing current and future demand for care workers, particularly migrant care workers, in an ageing society;
- the experiences of migrant workers, of their employers, and of older people in institutional care (residential and nursing care homes) and in home-based care;
- the implications of the employment of migrant workers in the care of older people for the working conditions of the migrants concerned and for the quality of care; and
- the implications of these findings for the future care of older people and for migration policy and practice.

We believe that the strength of this original inquiry lies in its cross-national comparative framework, use of interdisciplinary perspective, synthesis of available data, and generation of new data based on fieldwork with the different players. We bring the findings of this effort to bear on a range of policies affecting migration, working conditions, and the quality of care, with the intent of contributing to the improved care of today's and tomorrow's growing population of older persons.

The common goal of research in each of the four countries was to collect the perspectives of the major stakeholders, that is, migrant care workers, their employers, and their older clientele.³ The basic information gathered included reviews of institutional and contextual factors and secondary statistical sources. Data and projections on the older adult population and the migrant workforce were drawn from national databases, while important new information was gathered through extensive fieldwork in each country. The perspectives of all stakeholders were sought through individual and group interviews using common yet country-sensitive, semi-structured interview schedules, as well as with surveys which targeted employers.

The research effort sought to balance common protocol with an open-ended exploration of emergent themes. In order to inform the discussion from the workers' perspective, approximately 200 migrant care workers were interviewed across the four countries on their experiences in providing care to older persons, their care relationships with older people, and their working conditions. Older people were interviewed about their use of social care services and about their perceptions and experiences of their care relationships with foreign-born workers. Additionally, online surveys and national postal surveys, using protocol jointly developed by the national teams, collected information from more than 1,500 employers in geographically diverse settings. Employers reported on their recruitment and retention of workers and the advantages and challenges of employing migrant workers in care of older persons. In turn, just over 200 employers were interviewed on their experiences in employing migrant care workers. Details of the data collection and research methodology adopted in the four country studies can be found in the national reports listed in Appendix 3 following this comparative overview.

Finally, the international team had different interdisciplinary perspectives which generated observations strengthened by their interaction. Each team bears a unique perspective on the subject of migrant workers and contributed knowledge from the health sciences, gerontology, demography, anthropology, sociology, social policy, political science, and international migration studies. A coordinated methodological approach, based on regular conferences and information sharing, formed the basis for our inquiry and this synthesis report. Interested readers can consult the four national reports for greater depth.

The following report begins with an examination of the context of the current situation in each of the four countries, focusing on the demographic trends and projections of population ageing and the eldercare workforce. An examination of the national migration policies currently in place and current and historical patterns for migrant caregiver flows follows. We then present the research findings on workplace conditions and relations between employers, migrant care workers, and co-workers, and on relations between older people and migrant care workers, followed by a discussion of the factors shaping employer demand and recruitment of migrant caregivers. The report closes with conclusions on the state of the eldercare workforce and recommendations on how to manage the role of migrant care workers through policies that enable timely supply of the eldercare workforce, better training of migrant caregivers, and better incentives for native workers to assume a larger share of these positions.

THE CONTEXT

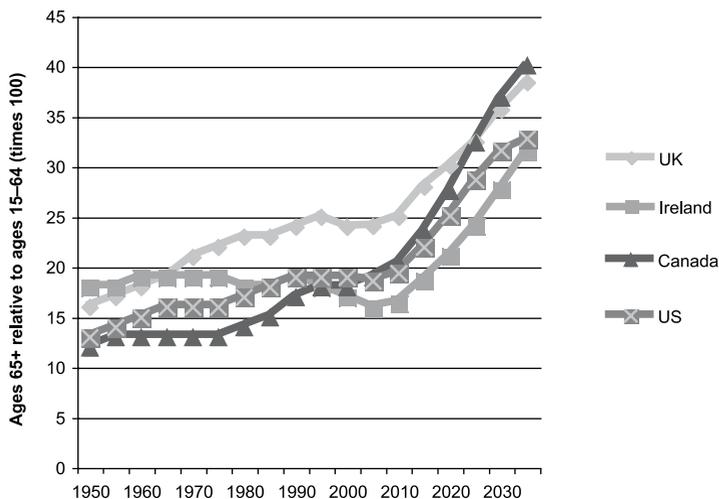
Today's and tomorrow's demand for migrants in the care of the elderly is driven by many factors. A primary factor is the demographic change toward ageing societies where the number of persons aged 65 and older continues to grow relative to those in the working ages of 15 to 64. Part of the demographic story also lies in the choices natives make in how they form families or the jobs they prefer. Beyond the demographics, each nation makes choices about how care is funded, the level of funding for care, and the settings of care. Wages are also part of the dynamic, given that the long-stay sector may tend toward low-wage jobs that fail to attract natives in sufficient numbers. Finally, in a global economy, the mobility of migrants makes them obvious candidates for all manner of jobs and, as this report demonstrates, many find their way into long-term care for the elderly.

Demographic trends, demand for eldercare and domestic shortages

Future demographic trends will increase the demand for care services for the elderly. All developed nations are ageing and the percentage of the population over age 65 is increasing rapidly. At the same time, the population in the working ages of 15 to 64 years will decrease in size relative to the elderly. The increasing number of elderly will generate demand for more caregivers, while their growth relative to the working-age population will accentuate supply-side bottlenecks. There are already concerns in all countries about current shortages, or fears that they are imminent.

Although projections are based on a set of assumptions and there is some degree of uncertainty about future trends, the workforce will need to expand considerably to meet the care needs of an ageing population. Figure 1 shows the old-age ratio of the population aged 65 and over to the 15- to 64-year-old working-age population (expressed in 100s). Growth in the number of the elderly was slow but steady in the last century, whereas the number of elderly relative to working-age persons is expected to increase significantly. The old-age ratio for the four nations in this study increased from an average of 15 to 20 over the 55 years from 1950 to 2005 (32% increase). The ratio is now projected to increase much more rapidly from 20 to 36 in just the 20 years to 2035 (84% increase). The ratio increase is projected to be greatest in Canada (111%), followed by Ireland (98%), the United States (76%) and the UK (59%). At the same time, the UK has an old-age ratio that is substantially greater than that in the other nations since the 1970s.

Figure 1: Old-age dependency ratio, 1950–2035



Source: United Nations and National projections.

Projections of shortages, however, might be premature for several reasons. The future availability of family and friends to provide both formal and informal care and the scope for technological developments to reduce demand are factors in the equation. Declining fertility in developed countries may lead to a higher labour force participation rate of women in the future, thereby expanding the pool of potential indigenous paid care workers. In addition, as proportionally larger numbers of older people will be living with their spouses, the consequences of a decline in any support from adult children may be less severe than is sometimes anticipated (Pickard et al., 2000). The use of new methods and new technologies may also reduce demand for caregiving (Hoenig et al., 2003). If family and spouses in particular remain reliable caregivers and new technologies continue to evolve, at least some of the growing demand will be met.

From the perspective of economics, the notion of future domestic shortages should seem odd as any under-supply should lead to wage increases and, in turn, induce increased domestic supply. The nature of the health and social care sector, however, is such that standard market mechanisms may not apply. Raghuram and Kofman (2002) argue that immigration policy might offset a supply of domestic workers. Governments may alter policy so that any under-supply of domestic care workers is met with more foreign-born workers, as opposed to wage increases. As states have an incentive to constrain wage inflation in the health sector, foreign recruitment, from their perspective, is likely to be attractive. Of course, even the provision of private health care might lead to the same scenario if the industry successfully lobbies for

more foreign-born caregivers. While such a scenario is possible it is worthwhile noting that, other than in Canada,⁴ there has been little evidence of any move toward liberalizing admission for workers in eldercare.⁵ At the same time, immigration policy is not the only non-market factor affecting wages in social and professional care. Funding constraints in a labour-intensive long-term care sector can also stifle wages. As so much of the funding for long-term care goes to labour costs, limitations and cuts to public and private funding may limit what workers earn. Also, social care in particular is viewed in some host countries as a low-status occupation, leading many in the workforce to opt for other lower-skill employment opportunities that carry greater social status regardless of pay.

Social Care and Health Care

Social care in this context refers to the provision of *long-term care* for people who require assistance with essential activities of daily living, including personal care and domestic tasks. It includes institutional care settings, residential and nursing homes, and community care for people living at home and receiving home care services.

Health care refers to more acute attention to clients and requires specific medical knowledge for the administration of medicines, therapy and other forms of medical treatment. Individual workers and providers must be licensed professional nurses or practical nurses with unique certification required from individual host countries.

Yet, there is a fairly common perception that current shortages already exist and that belief is, perhaps, most strongly supported in relation to professional care. There is evidence that many countries are experiencing a shortage of registered nurses (Stewart et al., 2007). In Canada, research on the nursing workforce (that does not separately address long-term care) identifies current and future nursing shortages, particularly with Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) (CNA Annual Report, 2009). Compared to acute care hospitals, the long-term care sector has the lowest nurse-to-patient ratios (O'Brien-Pallas, 2004b). Despite a recent improvement in nurse-patient ratios in the United States, it is thought that future shortages are imminent due to ageing of the workforce and low levels of training (Buerhaus et al., 2009). Current or pending shortages are thought to be driven by escalating demand for care, difficult working conditions and concurrent problems with turnover or retention, and ageing of the trained workforce.

There is also a common perception that there are shortages of social or direct caregivers in all four countries included in this report. In the United States, a prestigious panel of experts recently reported shortages of both professional and direct caregivers, calling attention to what it terms an “impending crisis”

(IOM, 2008). In the UK, one study modelling older people's future demand for informal care found that demand is projected to exceed supply by 2017, with the care gap widening in the following decades and reaching almost 250,000 care providers by 2041 (Pickard, 2008). Several reasons are given for these shortages; common across all countries are problems with funding to the sector, as well as high turnover associated with heavy and long work days. One study in Canada found turnover in home care to be two to three times higher than in other health-care sectors (Denton et al., 2006).

Location and funding of long-term care

Home is the dominant care setting for a majority of older care recipients. The desire of older adults to be looked after at home and the lower financial costs involved with home care make home the most common setting for the majority of long-term care provision. Home care environments are broadly and narrowly defined within the range of available facilities. For the countries in the study, home care offers little in the way of universal terminology standards or comprehensive data. Home care can refer to care provided in the home of the older person or a relative, or group residential environments where care, including both health and social care, is provided by a broad range of paid and unpaid caregivers either directly or indirectly employed by the care recipient. With some exceptions, home care settings tend to employ more low-skilled workers in the provision of social care, with some care recipients acting as both employer and client.

More formalized group or institutional settings include hospitals, public long-stay facilities, private nursing homes, adult day-care centres, adult foster homes, assisted living facilities, private group homes, respite care facilities and community care centres. Residential and hospital care settings often provide both chronic care and long-term care facilities. Formal institutional settings tend to attract a greater share of migrant workers who can assume professional care positions, such as nurses and physicians.

Funding is a key dimension that affects the type and place of care and the supply of workers that provide long-term care. Long-term care provision across the four countries coincides with an increasing demand for long-term care services and there is a marked increase in funding for these services. As the population ages and the share of the elderly increases, the demands for long-term care services are also expected to rise. In 2005, long-term care expenditures amounted to over 1 per cent of gross domestic product (GDP) across Organisation for Economic Co-operation and Development (OECD) countries (OECD Health Data, 2008), but this is projected to account for between 2 per cent and 4 per cent of GDP by the year 2050

(Oliveira Martins et al., 2006). There are differences across the four countries, with long-term care spending in Ireland, for example, at 0.62 per cent of GDP – a relatively low figure in the context of other OECD countries. Funding for these expenditures comes from public and private sources, with additional means of provision including the voluntary investment of personal time and resources from family members and friends.

According to a 2009 OECD report on the long-term care workforce, expenditures on long-term nursing care in 2005–2006 represented 9 per cent of total health spending, on average, across 24 OECD countries (Fujisawa and Colombo, 2009). Differences in funding for health care across the four countries in this study affect the place and provision of care. The location for long-term care for older people largely depends on the recipient's families, who provide the bulk of care in the home (Timonen and Doyle, 2008). Though family and friends take up a substantial portion of the costs for elderly care, the majority of health-care funding comes from the public sector. To varying degrees, Canada, Ireland, and the UK generally rely on public health and welfare programmes for funding, though the provision of services, as is the case in the UK, might be dominated by the private sector. The United States relies much more on private investment in health care. In the UK and Ireland, public funding is a key dimension in the employment of migrant workers. Migrant caregivers are mainly employed by private sector organizations, which are predominantly publicly funded, and, to a lesser extent, by the public sector, which has more sought-after positions related to marked wage differentials paid by public and private providers.

In Canada, private sector homes constitute 54 per cent of the ownership of long-stay facilities with not-for-profit (24%) and government (22%) making up the rest (Statistics Canada, 2007b). The provision of care in Canada is delivered through home care settings (all provinces provide three types of home care – post-acute, supportive care for the chronically disabled, and end-of-life care), community-based settings, and institutional care in long-term care settings. In the United States, the nursing home or nursing facility is the primary institutional setting for long-term care. Proprietary homes accounted for 62 per cent of all facilities; 31 per cent were non-profit, and the remainder were government-sponsored. Approximately 88 per cent of the facilities were both Medicare- and Medicaid-certified. In Ireland, 58 per cent of long-stay care beds are provided by private nursing homes, the majority of which are supported by public funding. The remainder of the long-stay care beds is a combination of public (33%) and voluntary provision of care (9%).

Due to changes in health-care sectors and increasing costs in acute care, the settings or places where long-term care services are provided, and the desire of older

people to remain in their own homes, there has been a general shift toward home care settings – with some exceptions. The residential care sector in Ireland remains strong and indeed may be enhanced by recent changes in funding arrangements. Though home care settings have been the dominant site of older adult care due to informal care arrangements among family, friends and the greater community, formalized home care is on the rise. In some instances, the care recipient can act as the direct employer for caregivers as well. In Canada, despite the rapid rise of expenditures for home care settings, funding for home care settings and community care has not increased, causing greater concern among home eldercare providers as expenditures outgrow budgets (MacAdam, 2004).

There are also a significant number of unregulated home care providers, such as personal support workers or health-care aides, who perform duties previously taken by nurses (Sharkey et al., 2003). In the UK, the trend toward home care may be attributed to community care reforms, first introduced in 1993, and the governmental desire to personalize eldercare by allowing users to control the services they receive. Approximately 1.7 million older people are currently receiving informal care from family or friends providing unpaid assistance with daily activities. While unpaid caregivers still dominate in nearly all countries, the scope of possibilities for long-term care, especially in home care environments, is expanding. In the United States, there are more than 9,000 Medicare-certified home health agencies. In Ireland, while the official policy was to support older people in their homes for as long as possible, there was no corresponding state investment until the introduction of home support packages in 2005. These packages are considered to be fragmented in provision and insufficient to cope with needs for community care. Moreover, recent changes in funding arrangements to support residential care may, once again, bias care away from community-based care. There has been an increase in private provision of home-based care in recent years, but the family remains the bulwark of community-based care in Ireland.

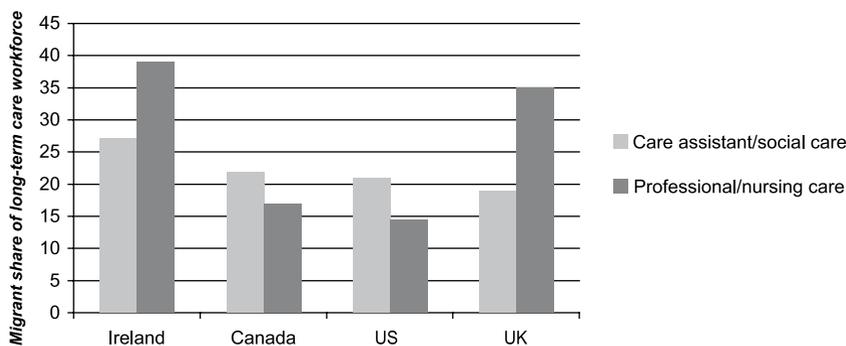
The labour market for eldercare jobs exhibits some characteristics that distinguish it within the health-care sector. For example, long-term care positions tend to be dominated by women and are often lower-paid than other low-skilled positions. For many of the residential and home-based care organizations, the work environment can isolate migrant workers, compounding the separation from society experienced by migrants in host countries and effectively creating double isolation for migrant caregivers. The eldercare sector is generally a low priority in the four host countries and the lack of attention to the sector has resulted in inconsistencies in the regulations to manage the various settings now employed to administer eldercare. These inconsistencies can negatively affect the working environment, the quality of care and the delivery methods for various care types.

Migrants in professional and direct/social care play a substantial role

Based on current trends, projections for the ageing population, and the expected shortages in the eldercare workforce, research indicates that the role of migrant workers in elderly care will increase in the future. Migrant workers already have a substantial presence in the delivery of elderly care in all four countries, and growth in the share of migrants hired for eldercare positions has steadily increased over the past few years. Available data show that this is true for both social care positions and professional occupations. Current projections indicate that the role of migrants will further increase over time.

Figure 2 provides a snapshot of the share of migrant workers by occupational or care type across the four countries, with data for 2007–2008 drawn largely from national employer surveys and national survey data. Data from the UK employer survey show that migrant workers account for 19 per cent of care workers and 35 per cent of nurses employed in long-term care, that is, they are significantly over-represented in the sector relative to the general workforce (13% were foreign-born in 2008 according to Labour Force Survey (LFS) data). The migrant shares of the workforce hired in the year preceding our survey (28% of care workers and 45% of nurses) suggest that reliance on migrant care workers is on the rise – a trend confirmed by estimates based on LFS data. Regional LFS data also show that migrant care workers are overly concentrated in the south of England (in London, more than 60% of all care workers are foreign-born).

Figure 2: Migrants in the long-term care workforce (%)



Source: Surveys of employers (UK and Ireland), American Community Survey (U.S.), IPUMS International (Canada).

In the United States, estimates from data for 2005–2007 indicate that migrant care workers make up more than 19 per cent of the eldercare workforce. The Bureau

of Labour Statistics predicts that eldercare occupations will be among the fastest-growing occupations in the United States between 2006 and 2016. In Ireland, 27 per cent of care assistants (social care workers) caring for older people are migrant workers. This marks an over-representation of migrant workers in older adult care relative to the general health and social care sector (16%) and the general labour workforce (15%). Recent data were not available for Canada; however, data for 2001 suggest that migrant care workers account for a significant portion of the eldercare workforce in Canada.

Migrant workers coming into each of the four countries specifically to work in the care sector bear distinct qualifications, unique certifications, a highly diverse set of experiences, as well as differing norms and styles in the delivery of eldercare. As a result, experienced workers bring distinct skill sets and differences in the practice of long-term care, whereas those who enter without prior experience in these types of jobs may not. The experience level differs greatly across admission classes and even workers with experience and certification may be required to undertake additional training and certification upon arrival in the host country. The range of workers with relevant experience includes practical nurses, registered nurses, physical and occupational therapists, physicians, care managers, home support workers and other home care occupations.

Though data availability and definitions differ, some generalities appear for care worker types and the data from the employer surveys are largely consistent with existing national censuses and surveys. The comparison of our survey data with national data sets also confirms the previously documented over-representation of migrant nurses in nursing homes in the independent sector (private and voluntary) (Ball and Pike, 2007). For example, in the UK, migrant nurses account for 35 per cent of the nursing workforce in older adult care, a figure which is considerably higher than the share of foreign-born workers in the overall nursing workforce (23%, as estimated by the UK LFS). The same is true in Ireland, where foreign nationals make up a far larger portion of the adult care workforce in comparison to their share of the general health-care workforce.

Comparing the migrant share of the workforce in the two occupations across the four countries also shows that, while in the UK and Ireland, migrants account for a higher percentage of nursing occupations, foreign-born workers constitute a greater percentage of social care positions in the United States and Canada. In absolute terms, however, the actual numbers of social care workers are greater than those of professionals in all four nations.

We do not know the reasons why migrants concentrate in more-skilled jobs in the UK and Ireland and lesser-skilled jobs in the United States and Canada. On the one hand, there are several reasons for the relative concentration in social care positions of migrant workers in the United States and Canada. First, direct or social care jobs are readily available, they tend to be unregulated, and there is increasing demand for workers in direct care positions. In the United States, direct care providers already account for roughly 80 per cent of all long-term care workers. Social care positions are much easier to supply than professional care positions that require special training, certification, language ability or knowledge of health-care practices. Also, there may be a general lack of interest on the part of native workers in pursuing direct care positions. On the other hand, the reliance on nurses in the UK and Ireland may be driven by a shortage of native nurses due, in part, to their preference for the more attractive jobs in public hospitals and acute care settings. Indeed, it may be (as also demonstrated in US data) that whether professional or social caregivers, migrants tend to concentrate in least-formal care settings. Further, in the UK, Ireland and several Canadian provinces, government agencies have established bilateral agreements with India and the Philippines to actively recruit nurses and they may have become the preferred workforce in long-term care for older persons.

MIGRATION POLICIES AND PATTERNS

The policies that govern the eldercare sector and the migration patterns that affect the individual country labour markets vary significantly. Each country has unique policies for the recruitment, admission and retention of foreign-born workers and each has developed policies based on current and historical patterns. While the UK, Canada and the United States each has a long history as a host country, Ireland has more recently been affected by an influx of migrant workers. This section explores some of the policies that have a direct influence on eldercare employment and the migration patterns that result from or perhaps influence the development of policies for the sector.

Policies

In all four countries, admission policies historically tended to favour admissions for family reunification over employment and, with the exception of Canada and a limited entry channel in the UK, none target admission of long-term care workers. There was a shift toward meeting labour market needs in Canada some two decades ago and in the UK, nearly one-and-a-half decades ago. The United States cobbled together a system that has increased the admissions of skilled temporary workers since the mid-1990s; temporary workers to some extent increasingly characterize all four nations. Ireland stands out as a nation formerly known for emigration that became a nation of significant immigration in the latter 1990s. Otherwise, because of the policies of the European Union, both the UK and Ireland differ substantially from the United States and Canada in terms of favouring migrants within the EU. Despite these notable policy differences, there are similarities in the relationship between admission policies and migrants who find work in long-term care.

Migrants in long-term care jobs are largely admitted outside of targeted visa classes

Migrant workers in both professional and social care are often admitted outside of employment or targeted visa classes. All of the nations in this study, to varying degrees, have skilled classes that admit registered nurses, physicians and other health-care professionals. Admission to the host country generally requires a review of health-care credentials, qualifying exams or certification in the host country health-care system, and English language proficiency examinations. However, these visas are not earmarked for professional workers in long-term care. Lesser-skilled social caregivers, on the other hand, tend to arrive through visa classes for family reunification, refuge or asylum, and, only extremely infrequently, with employment visas. At the same time, in Ireland and the UK, the expansion of the EU has increased

the pool of lesser-skilled workers from the new accession countries, which, in turn, have been an important supply of social care workers. Indeed, most care assistants in Ireland since 2004 have come from the new accession or “A8” countries. In reality, EU policy has shaped labour pools in Europe, making it more difficult for non-EU care workers to enter through existing labour migration channels.

There are two notable exceptions to the lack of special visas for long-term care workers: Canada’s Live-In Caregiver Program (LCP) and exceptions for senior care workers in the UK. The Canadian LCP allows migrant caregivers admission to Canada provided they fulfil certain criteria prior to and after admission.⁶ The inflow of foreign-born workers who come to Canada under the LCP has increased gradually from around 2,000 in 1996 to 6,717 in 2007 (CIC, 2008), though the number of applicants dropped most recently in 2008 and 2009, largely due to the economic downturn. The vast majority of workers coming through the LCP were women from the Philippines (83%), followed by those coming from Britain (2.3%), Slovakia (1.6%) and Jamaica (1.7%) (CIC, 2008). Of those workers admitted to Canada through the LCP, more than 6,800 have become permanent residents (CIC, 2007). The growth and increasing popularity of the programme indicate that there is place for admission classes targeting social caregivers, but the temporary nature of the programme does little to provide stability to the long-term care workforce. Furthermore, some observers note that workers are underemployed relative to their education; some are also critical of how temporary live-in status affects working conditions (Spitzer and Torres, 2008).

In the UK, there is an ongoing debate about how best to control the flow of migrants into social care positions. The immigration channel for so-called senior care workers was previously used by significant numbers of non-EU social care workers; over 22,000 visas were issued between 2001 and 2006. However, it has been restricted by the introduction of more stringent criteria and now provides limited opportunities to work in care of older persons. These positions have generally been considered low-skilled posts that do not require qualifications at the bachelor degree-level and tend to receive low hourly wages. In 2007, the UK Home Office determined that senior care worker positions should no longer qualify for a shortage occupation list for fast-tracked admission, unless they meet certain criteria. Currently classified as non-priority in the UK points-based system, senior care worker positions require formal qualifications, two years of certified experience, employment in supervisory roles, and remuneration above a minimum wage threshold. Most observers believe the recent policy changes will make it difficult for employers to recruit outside the EU and for migrant workers to renew their working visas, while wage criteria may create disparities in the workplace.

Codes of practice on international recruitment

Coinciding with the increasing demand for migrant health-care workers is an increase in international recruitment. Recruitment efforts use both direct and traditional advertising by employers, state-sponsored recruitment in target countries such as the efforts undertaken by Ireland and the UK, and specialized recruitment agencies located in the host country and abroad. The range of practices used by recruitment agents and employers varies widely, with limited codes of practice regulating international recruitment. There are policies affecting the general international recruitment of migrant health-care workers; however, few are specific to health-care and social care workers. The major exception to this is the UK, where the government has instituted a Code of Practice for the Active Recruitment of Healthcare Professionals, which is to be followed by the National Health Services. As the name suggests, the Code applies specifically to the recruitment of professional health-care workers, limiting recruitment by the National Health Service unless approved by the source country. While the code has improved the recruitment practices of overseas health-care professionals, it is not comprehensive – it is voluntary for the private sector and does not prohibit direct recruitment by health-care professionals. There is less proscription for social care workers, but some codes of practice are emerging to protect their rights in the workplace and ensure that client needs are adequately met by staff with minimal language and health-care skills. The World Health Assembly recently approved the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel to promote voluntary principles and practices for host and source countries. Voluntary codes of conduct exist in the United States and other nations that attempt to improve recruitment in health care but, again, these often fail to address non-professionals in long-term care.

Patterns of migration

The supply of migrant workers comes from countries both nearby and far away, primarily from developing nations. Perhaps unsurprisingly, a substantial share of migrant workers in the UK and Ireland come from other European nations, while in the United States and, to a lesser extent, Canada, they come from the Americas. More striking is that in all four countries, professional migrant caregivers often come from Asia, especially the Philippines, while there is a far greater diversity of migrant origins in the lesser-skilled social care occupations. A study of major source countries – Poland, Jamaica, India, and the Philippines – sheds some light on the variety of ways in which the international supply of migrants is organized.

Some similar source countries, but notable differences

The distribution of countries of origin of eldercare workers shows some similarities across countries, but there are differences in migrant flows by occupation type. While the areas of origin have changed over time for each of the four countries, some clear patterns can be seen in the flow of migrant eldercare workers. Geographic proximity to the host country and humanitarian migration flows certainly play a critical role in determining migration patterns for many of the eldercare workers employed in direct and social care positions. While this can also be seen in the patterns for professional care positions and nursing, it is the recruitment efforts located in specific countries, such as the Philippines and India, which bear the greatest influence over the hiring of migrant nurses and professional care workers in the host countries.

Table 1 shows the leading countries of origin of eldercare workers within each host country. The data indicate that, with regard to the foreign-born social care workforce, all four countries have large proportions of Filipinas in all areas of eldercare employment. However, the data also show that, while Filipinas assume both direct and professional care positions, the proportion of Filipinas is much larger in professional care occupations. The large proportion of Filipina workers in nursing and professional care holds for all four countries. The balance of the direct care positions held by foreign-born workers in each of the settings tends to be from nearby countries or those with established flows of migrant workers. These direct care positions are easier to obtain in the host countries and far less international recruitment is needed – though some recruitment does take place in countries such as Slovakia and Poland – for vacancies that are more easily and less expensively occupied through traditional means of local advertising and hiring.

Table 1: Areas of origin of large shares of the eldercare workforce

Country	Direct/Social Care Workers	Nurses/Professional Care Workers
Canada	Philippines Other Asian countries Sub-Saharan Africa	Philippines The Caribbean Europe Latin America
Ireland	Poland Philippines Nigeria	India Philippines
United Kingdom	Philippines Poland Nigeria Zimbabwe	India Philippines Sub-Saharan Africa
United States	The Caribbean Mexico Philippines	The Caribbean Philippines Sub-Saharan Africa

With regard to the foreign-born social care workforce in Ireland and the UK, foreign-born workers from the Philippines, Poland and sub-Saharan Africa take up significant portions of the lesser-skilled eldercare positions, with workers from other European and regional countries assuming the remainder. Workers from sub-Saharan Africa also make up large portions of the foreign-born direct care workforce in Canada and the United States. However, it is workers migrating from Mexico and the Caribbean who share the largest portions of these positions in North American countries, with some Latin American countries and other Asian countries comprising the majority of the remaining share.

In addition to workers from the Philippines, there are a number of professional care workers and nurses from India, particularly in Ireland and the UK. This is due in part to recruitment efforts, such as Ireland's efforts to recruit nurses abroad, and in part to established flows of migrant workers. Of the employers surveyed in Ireland, roughly 75 per cent reported that India is the first country of origin for migrant nurses working in Ireland, and 21 per cent reported the Philippines as the primary source country. In Ireland and the UK, there has also been a recent surge in migrant care workers from Poland. The flow of Polish care workers to these two settings follows the general trend of Eastern European workers migrating to Ireland and the UK in search of higher-paid employment opportunities.

Source country supply stories

In order to form a more complete understanding of the supply-side story, case studies were conducted in 2008 and 2009 on recruitment in source countries common to the participating countries. In this study we did not address the impact of that recruitment on the source countries. While each of the four countries attracts and recruits a unique mix of migrant workers to work in eldercare professions, there are some characteristics of the supplying and recipient countries that link source countries to host countries. Changes to the host countries' immigration quotas and policies within a source country can combine to create an ideal situation for the movement of migrant care workers from one country to another. The case studies conducted for Poland, Philippines, India and Jamaica provide insights into the policies and histories of both host and supply countries. These stories illustrate some of the influences that affect migrant flows and the formation of training, regulation, and migration policies in source and host countries.

Poland

The influx of Polish caregivers into Ireland and the UK is a relatively recent phenomenon, coinciding with the expansion of the EU in 2004. Highlighting this tremendous increase is the fact that more than 90 per cent of the Polish immigrants in Ireland arrived after 2004 (Goździak, 2008). As a result of this policy change and migration shift, the number of migrant care workers moving from Poland to Ireland and the UK has also increased substantially over that time. The majority of these workers assume direct or social care positions, with a smaller percentage of migrant caregivers assuming professional care or nursing positions. Nearly one third of the employers participating in an online survey in Ireland found that Poland was a primary source of migrant workers. Though formal recruitment schemes have been established in Poland, these have had a lesser effect on the flow of Polish migrants than simpler, indirect means. Many of the Polish migrant workers, particularly direct care workers, found employment through informal networks and word-of-mouth contacts at home and abroad.

In the UK, data from the LFS are consistent with online employer surveys in reporting that Poland is among the top three sending countries for migrant caregivers in the UK. In the UK, one in four of the newly arrived social caregivers is from Poland, though by no means have all migrated specifically for eldercare employment opportunities. Many arrive in search of better-paying jobs and quality working conditions. It has been noted that direct caregivers from Poland often change fields or positions and many follow a circular migration pattern, returning to Poland after a period of employment in direct care positions. Though circular migration for Polish

migrants is common, many Polish nurses reside in the UK permanently or for more extended periods. Polish nurses employed in Ireland and the UK find fewer reasons to leave secure and high-paid nursing positions that are not as well-rewarded at home.

Philippines

Caregivers from the Philippines dominate eldercare positions across the four settings, taking positions as both nurses and direct caregivers. While social caregivers from the Philippines represent a large share of the foreign-born social care workforce, it is Philippine nurses in particular who are assuming an increasing share of the professional care positions in long-term care settings in the developed world. Nurses from the Philippines occupy positions in hospitals, institutions, nursing homes and informal care settings. Because English-speaking countries constitute the most popular destination for migrant nurses and because the Philippines has such a well-developed nursing system, the migration of Philippine nurses into the four settings has evolved over time into a well-organized, efficient system of human labour transfer. As of 2004, the Philippines had become the largest international exporter of nurses. Estimates on the LCP in Canada indicate that the number of Philippine nurses entering the system is increasing (Langevin and Belleau, 2000) and that, currently, Philippine nurses comprise the vast majority of the workers in the programme (CIC, 2008).

The strength of the Philippine nursing export model is rooted in a long tradition of human labour export from the Philippines and the burgeoning availability of nursing and caregiver education in the country. The Philippine Overseas Employment Administration (POEA) is a state institution whose role is to manage the export of human labour from the Philippines more efficiently. The POEA manages the flow of migrant workers, mediates between private agencies and labourers, researches global markets, and protects the rights of overseas workers. Foreign institutions and recruiters wishing to hire Philippine nurses typically operate through this government system; however, there are a growing number of approved private recruiters. Previous research indicates that Canada and the UK tend to rely more on state involvement, whereas Ireland and the United States utilize more private recruiters and direct employer–employee arrangements.

Training for long-term care positions is a growing business in the Philippines, with an increasing number of nursing and vocational schools appearing to fulfil the demand for education that will provide opportunities abroad and improved job stability. Much of the current job training appears geared toward exports to Canada due to the recruitment and integration of first-level posts through the LCP. Some evidence of this is seen in the decreasing pass rates for the National Nursing Board

Exams in the Philippines. Despite the low pass rates, increased training opportunities have enabled a growing percentage of the population to gain access to professional and social care positions abroad. With these institutions expected to grow, the Philippine market is poised to remain the largest exporters of professional and social long-term caregivers.

India

Through existing migration flows and direct recruitment, India has well-established patterns of supplying professional care and nurses to all four countries. This pattern is strongest for Ireland and the UK where specific recruiting efforts have been made over the last decade. In Ireland, Indian professionals make up the greatest share of foreign-born nurses, likely the result of targeted recruiting efforts in 2005 and 2006 as part of the Dublin Academic Teaching Hospital (DATH) recruitment project. The 2006 efforts of DATH focused exclusively on India.

The United States also attracts a large share of Indian professional care workers through direct employer recruitment and recruitment agencies operating abroad. In 2007, there were 267 US-based recruitment firms, representing a tenfold increase from the late 1990s (Pittman et al., 2007). For many nurses originating from India, the paths to the United States are not direct. Professional care workers often migrate through other countries, such as the UK or Saudi Arabia, deciding to move to the United States for a host of personal and professional reasons. For some, bureaucratic regulations and time lags can present considerable obstacles to migration. One female nurse from India had been working in Dubai for 25 years when she decided that, despite the difficulties of transferring her skills abroad, she would take on the challenge of working in the United States. “I submitted all the paperwork in 2003 and was approved in early 2004, three days before my daughter’s 21st birthday. The entire process took over four years from beginning to end.”⁷⁷

Jamaica

Foremost among Caribbean countries in the provision of long-term care workers to the United States and Canada, Jamaica has gradually shifted from exporting large numbers of social caregivers to a larger share of professional care workers. Several reasons for the shift can be seen through policy changes in Jamaica that respond to the country’s domestic approach to labour supply and the growing demand for more professional care workers abroad. The Jamaican education system for nursing has improved dramatically over the past 20 years. Nursing schools and professional certifications are growing every year through an expansion of education facilities and changes to the structure of the education system under the national government.

An increasing number of internationally migrating nurses has accompanied the shift from a hospital-based system under the Ministry of Health to a university-based system under the Ministry of Education.

Intercountry flows of caregivers are small

As previously mentioned, English-speaking countries constitute the most popular destination in the global labour market for nurses. While the vast majority of migrant caregivers entering English-speaking markets are from non-English-speaking countries, there are intercountry flows between English-speaking countries that include migrant workers moving on and workers native to the sending country. Data on intercountry flows is limited, particularly for social caregivers, but there is evidence of these flows affecting both sending and recipient countries.

Migrant flows between the UK and Ireland can be seen for both caregivers and nurses. Data for 2007–2008 indicate that in the UK, caregivers migrating from Ireland, but not necessarily originating from Ireland, represented approximately 11 per cent of the non-recent immigrants. The same data show that migrants from Ireland represent about 18 per cent of the non-recent immigrant nurses in the UK. Among migrant nurses registering in Ireland in 2001, nurses from the UK were among the top five in terms of the share of newly arrived nurses to Ireland (Stewart et al., 2007).

Stepwise migration, which occurs when migrant workers move from one host country to another in search of enhanced employment opportunities, can often be attributed to economic and social factors in neighbouring countries. Ireland had historically exported nurses to both the UK and the United States, but it has attempted to curtail the outflow in more recent years and attract more foreign-born nurses due to shortages in its own professional care systems. The migration of registered nurses to the United States has been identified as a contributing factor to difficulties with the recruitment and retention of professional caregivers in Canada (O'Brien-Pallas et al., 2004a). Both the UK and Ireland draw a significant amount of caregivers from EU nationals and have historically attracted nurses from among EU nationals as well.

In the United States, Canada was second only to the Philippines in sending newly registered nurses to the United States (Aiken et al., 2004). In the UK and Ireland, there are verification data from nurses applying for jobs abroad, by country of destination and country of training, that indicate that there is a significant amount of stepwise migration occurring between countries. For example, more than 60 per cent of UK-registered nurses applying for jobs in the United States between 2003 and 2008 were trained outside the UK. The same principle for UK-registered

nurses applies to approximately one third of the nurses applying to go to Australia (Nursing and Midwifery Council, unpublished data). For nurses in Ireland, it is more common to submit a request for Australia and the United States; this trend tends to hold for Irish and foreign national nurses registered in Ireland. Qualitative research for Ireland (Humphries et al., 2008) suggests that the intention of migrant nurses to move to Australia, Canada and the United States is widespread. In particular, the most common reason to move to Canada is the more permissive immigration system providing more opportunities for settlement and family reunification.

WORKPLACE CONDITIONS AND RELATIONSHIPS

The recruitment of foreign-born care workers raises issues regarding the working conditions under which workers are employed and deliver care to older people, and the relationships between employers, foreign-born workers, and co-workers. For the most part, employers responding to the surveys in all four countries indicated that hiring foreign-born workers in eldercare positions had little impact on either the quality of care (Figure 3) or the relationship among employees and staff. Those that did see changes found the impact to be largely positive. However, from the perspective of employers some general issues did arise, particularly in relation to English language and other communication issues such as cultural knowledge and sensitivity to client needs in the host country. Migrant care workers and (as will be discussed later) older people also referred to difficulties in relation to English language ability. Cliquish behaviour and social exclusivity among both native workers and foreign-born workers was also seen by employers as having detrimental effects within the workplace, particularly when designed to deliberately exclude others. With regard to the experiences of migrant care workers, while some indicated satisfaction with employers and the working environment, experiences of poor terms and conditions, irregular employment practices, and discrimination were also indicated, particularly in home care settings, which were less regulated and where care recipients can be both client and employer.

English language ability is an important challenge in employing migrant care workers

Employers felt that language difficulties posed the greatest challenge to employing foreign-born workers in eldercare. Constraints with English language ability were not limited to grammar, vocabulary or knowledge of terminology. The use of slang and colloquialisms and difficulties with dialects were also considered by employers and by migrant workers to create challenges for communication in the workplace, even for migrant caregivers who may in fact speak English quite well. Migrants in Ireland reported reduced efficiency in performing regular, everyday tasks when operating with limited English proficiency. This was exacerbated by the use of expressions not common to the foreign-born workers. One US employer noted the problems that communication difficulties with English language ability can have on the client and the employer:

We hire a lot of immigrants... and they vary a lot on their backgrounds. Our residents complain a lot about the difficulty in understanding them and I believe this leads to non-acceptance; in return, the immigrant staff have a hard time forming respectful relationships with the residents. It takes a long time... to be accepted... and to provide the quality of care that our residents and our management demands.⁸

In some instances, it was the use of the foreign workers' native language that created barriers between foreign-born caregivers and their co-workers, including native workers and foreign-born workers of differing ethnic backgrounds. The native worker can view this behaviour at worst as a threat to job security and as a form of social exclusion. In Ireland, migrant caregivers speaking in their own language at work was seen by employers as inappropriate behaviour and potentially distressing to the clients. One Irish employer noted the problems this created in developing a cohesive and peaceful workplace: "Integration is a challenge as migrant workers often stick together and are not culturally cooperative with other migrant workers." In Canada and the UK, however, use of native languages was found in some cases to be an asset because of the diversity of the first languages of older adults in care.

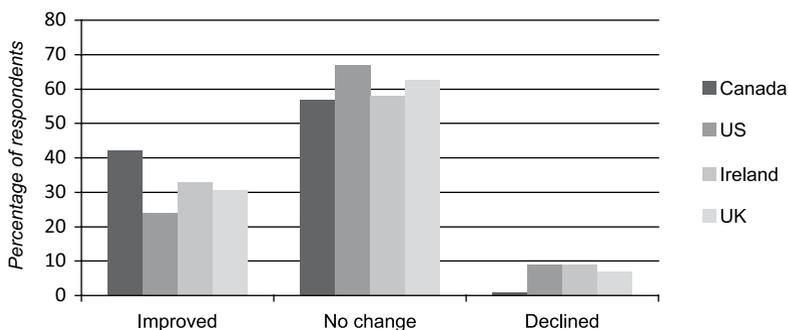
Language barriers were not necessarily as great a concern for migrant care workers in nursing homes who were assigned to care for individuals with difficulties communicating, such as those having suffered from dementia or stroke. In such cases, residents required workers who exhibited other forms of communication skills, such as patience, kindness, and attention to general client needs. In the UK, one caregiver explained this simple need for human care and understanding: "With residents who maybe their dementia has progressed very, very much they just needed somebody nice with smile and, you know, that's just good for them [*sic*]. So, the language wasn't as important."⁹ The ability of the care worker to be attentive and develop non-verbal communication skills to communicate with residents was therefore emphasized in such cases.

Other types of communication challenges were raised. Irish employers noted that a lack of a common cultural background and historical reference resulted in further difficulties between caregivers and their clients and co-workers. Sometimes these cultural differences can spill over into differences in how care is administered or received. One Canadian employer commented in the online survey that "employing immigrant workers often leads to conflict due to difficulty in communication and a belief that care should be delivered in a particular fashion." This can cause tension between the caregiver and both the client and co-workers. Native workers and foreign-born workers may disagree on the way that care is delivered, and subtleties in care delivery may cause conflict or stress in the workplace. It can also lead some employers to require additional training for some foreign workers to adjust to cultural differences or adjust to legal requirements in the delivery of elderly care.

Skills and caring are good; training would improve care

Employers in the four countries were asked about the impact of hiring foreign-born workers on the quality of care and staff relationships. Respondents overwhelmingly reported that there was little to no change to the quality of care and staff relationships after hiring migrant workers (Figure 3). This was true for nearly two thirds of all respondents in Canada, Ireland and the United States;¹⁰ however, those who did see a change in the quality of care or in staff relationship tended to view the impact as positive. In Canada, Ireland and United States, 42 per cent, 33 per cent and 24 per cent of the respondents, respectively, suggested that the quality of care had improved with the employment of migrant workers, with more than a quarter of the respondents suggesting that workplace relationships had also improved. Less than 10 per cent of the respondents in each of the three countries found that the quality of either care or worker relationships had deteriorated.

Figure 3: The effect of migrant workers on the quality of care



For the most part, employers reported that skills among migrant care workers, particularly in caring for the elderly, are good but additional training would improve care. Employers in all four nations report that the greatest challenge after English language ability is the need for additional training for migrants. The content of training is not primarily “medical” but is related to organizational culture, person-centred care, the care environment, and sensitivity to clients’ needs. This was found to be true for some employers in Ireland, but specifying the type of training necessary is complicated. An example was offered for migrant nurses in Ireland. The clinical skill set of migrant nurses was generally praised as appropriate and adequate to the care system, but these nurses’ ability to deal with and deliver social care to older people in a formal care system was highlighted as a potential issue. This is partly due to migrant caregivers coming from systems where families provide care in community-based settings rather than in residential care settings.

Discrimination and irregular employment practices impact the working conditions of migrant care workers

Racial and ethnic discrimination in the eldercare sector was evident in the experiences and perceptions of migrant caregivers and employers, and of care recipients. Discrimination here refers to less-favourable treatment without lawful grounds and is specific to ethnic and racial prejudices, not (in our evidence) to gender or age. It should be further mentioned that it is difficult to determine how widespread discrimination is in the eldercare sector, but that there was broad evidence of discrimination in the workplace and in hiring and recruitment. Some employers suggested preferences among native-born employees to work with other native-born workers and similar preferences from clients. Some caregivers reported discrimination on the part of employers regarding the scheduling of hours of work and responsibilities for different tasks, and regarding pay rates and overtime compensation. Caregivers also referred to experiences of verbal abuse from care recipients or native-born co-workers, and some clients expressed ethnic and racial prejudice towards foreign-born workers.

With regard to working conditions, some migrant caregivers considered native workers to receive special privileges not afforded to foreign workers. In Canada, some caregivers complained that the limited hours and poor shifts they were given compared to native workers created additional stress in the workplace and the home, as some of these workers had to take on a second job to make up for missed wages. In the UK, some caregivers also referred to being given unfavourable shifts, as indicated by a Polish caregiver: “For two years, every single Saturday and Sunday I was at work... I think it was most of the Polish people and Filipinos. It didn’t happen with English carers.” Differences in pay were also reported by some caregivers; indeed, LFS data in the UK show that foreign-born care workers tend to be concentrated at the lower end of the pay scale, within a sector marked by low wages overall for all care workers. By contrast, in the United States, data show that foreign-born care workers actually do better than natives on total earnings and number of hours worked. Migrant caregivers in Ireland did not indicate discrimination in relation to pay, but referred to the general discontent across all nationalities regarding low levels of pay in the eldercare sector.

Irregular terms and conditions and employment practices in the eldercare sector were also indicated by some migrant caregivers, pointing to issues concerning the employment rights of migrant care workers that extend beyond discrimination. Long hours of work that exceeded the terms and conditions specified by employment contracts and by employment law were reported, as well as lack of remuneration for hours worked and the withholding of wages. While some migrant care workers

referred to working long hours to compensate for low hourly rates of pay, others, particularly those who provided live-in care (living in the homes of older people), referred to long hours according to the needs of the client which were not always remunerated. In the UK, a South African caregiver who was employed by an older adult client to provide live-in care in the home commented: “There’s no agreement on that [hours of work]. I work continuously, continuously, provided I’m in the house.” Such problems arise for live-in caregivers due in part to a lack of regulation for home care settings.

Experiences of poor terms and conditions were reported in particular by caregivers whose immigration and/or employment status was irregular – including, for example, those who had overstayed their student visas and those who were employed irregularly by older people or their families (who did not fulfil responsibilities for employer tax/insurance contributions) to provide live-in care. In these cases, fear around the irregularity of their immigration status contributed to the lack of means of migrant caregivers to voice their complaints over their working conditions. Poor terms and conditions were also reported by those who were employed directly by older people or their families. The isolation from organizational sources of support and information on employment rights for those employed to provide live-in care, and the lack of regulation of the direct employment of migrant workers by older people and their families, may also have contributed to experiences of poor working conditions.

RELATIONSHIP BETWEEN OLDER ADULTS AND THEIR MIGRANT CARE WORKERS

In addition to interviews with migrant caregivers, discussions and interviews were conducted with older people who were currently receiving care services in institutional and home care settings and some who were prospective care users, in order to explore perceptions and experiences of the relationship between foreign caregivers and older people. In general, elderly clients expressed positive feelings toward foreign-born caregivers and were more concerned with the quality of care than the source. Factors that were found to contribute to constraints on the care relationship between clients and caregivers included language and communication issues, as well as factors relating to broader constraints on the quality of care, notably staff shortages and lack of time available to caregivers to attend to the needs of elderly clients, including time to form strong relationships.

Older adult clients tended to praise orientation towards care

Positive relationships between migrant caregivers and elderly clients were described by them as loving and caring, based on friendship or even familial. The care relationship between the caregiver and the client was perceived by both parties to be central to experiences of the quality of care.

Cultural stereotypes of “good” caregivers were evident in some older people’s perceptions of migrant caregivers of particular nationalities, for example, in relation to Filipino workers by a Canadian care recipient. “You have different characters in every nationality. You know, you take like Filipinos, they’re very soft people, very caring people.” Some elderly clients perceived foreign caregivers to be more attuned to client needs than native workers because of a deep respect and care for elders, which they perceived to be present in the cultural or religious beliefs of the foreign caregiver. Another care recipient in Canada suggested that Filipino caregivers are accustomed to long-term care for the elderly as it is part of everyday life:

I did notice that the people that were from abroad, in particular the people that we had come in from, like, the Philippines, I noticed that...they have a little bit different attitude towards the elderly. The whole families look after them. ...I’ve lived in the Philippines as well and I’ve seen how their care system works and the whole families look after the elderly. And I don’t even think I saw one care facility the whole time I lived in the Philippines.¹¹

Some migrant caregivers similarly perceived their care-related skills in relation to notions of cultural norms and religious beliefs. A caregiver in Ireland referred to familial care as being obligatory with few, if any, alternatives. “Because in our country, you have to mind your own elders...you have to keep them in your home and mind them because we do not have nursing homes.”¹² A caregiver in Canada described her ability to care and to be attentive to the needs of older people in terms of her religious beliefs. “I always liked to be there and be useful for the elderly. That I find is something which is very, very important. In my religion, it is an important part – to help sick people. That I like as well. Also to approach and to speak to them, I really like that very much [*sic*].”

“Good” care was not simply perceived as being influenced by cultural or religious norms. Communication was an important factor that shaped positive experiences of care for both elderly clients and migrant caregivers. Having someone to talk to and relate with was perceived as critical by care recipients and prospective care users. A prospective care recipient in the UK referred to the importance of sharing a conversation with a caregiver to cope with loneliness. “I think somebody who would listen to me. I think that would be important, and I am assuming that if I had care I would maybe be on my own and I suppose I would like someone I could talk to and share a bit of humour with.”¹³ The notion that relationships and communication are a key part of elderly care that goes beyond clinical care requirements was similarly expressed by many of the migrant caregivers. A Filipino caregiver in the UK referred to the importance of listening and speaking with clients. “To pay attention to them because they are, of course, they are lonely because they live alone. Some of them have no family at all and no one to talk to. And so, yes, listening to them is a must.”

As will be explored in the next section, given the importance of communication, language difficulties and other communication issues were perceived by older people and by migrant caregivers as constraints on relationships between elderly clients and caregivers. Discrimination towards migrant caregivers also had a negative impact on the provision of care. Broader issues affecting the quality of care, including staff shortages and a lack of time to deliver care and to talk to older people, were conveyed by migrant care workers and by older people as a constraint on care relationships.

Language difficulties are a barrier

Care recipients referred to language and communication barriers negatively affecting experiences with some migrant caregivers. Understanding what the client or the caregiver is saying is a critical issue when dealing with issues related to health care, especially with the elderly. It is also critical to developing relationships between

clients and caregivers, as emphasized by one elderly client in the UK: “Another point, I think, is the language barrier. You know, we don’t understand, and you can’t always joke because they don’t understand the joke. It’s a bit difficult but you do try.”

Migrant caregivers depicted similar problems with language and communication. A Zimbabwean caregiver in the UK indicated that there were two-way problems with understanding accents. “I find it hard myself, it is sometimes hard to explain myself to older people you know, because of the accent, and I can’t understand some of them, they have got a typical strong accent.”¹⁴ Those workers who had experienced difficulty with the English language expressed frustration in making the transition to working in their host country, as described by a Polish caregiver in the UK: “First few weeks, what I remember, I just felt like crying. I felt like completely a fool because I couldn’t speak in this language and I couldn’t communicate with people. So it was very, very hard for me. And, you know, not to be able to express myself and say what I want to say.”

Migrant caregivers mentioned needing adequate time to get used to new accents, dialects and to generally improve English language skills. After an initial adjustment and with access to English language training, either within the workplace or through external training providers, those interviewed suggested that relationships with caregivers improved. A foreign caregiver in Canada talked about the transition period:

I have had some difficulties at the beginning because my English was very poor once I came to Canada. Now I feel pretty much okay because my clients, they understand me. They don’t feel any difficulties to understand me to see what I want, to see what I want for them, and to understand them, so now it’s pretty much okay.¹⁵

Other caregivers and recipients suggested that communication issues extended beyond language ability or accents, also concerning differences in cultural competency. One elderly client in Canada perceived migrant caregivers to lack understanding of cultural norms of care:

It’s also my experience the difference in how I’m treated. You know, a young immigrant worker doesn’t have the same understanding of how it feels when you get turned over and the tube is being yanked the wrong way or, you know? They don’t have the same, same training or the same care. I don’t know what it is but it’s just not there.¹⁶

For some caregivers, this level of personal knowledge was important to understand clients and their needs. Much of this training is informal and requires mentoring and guidance from native caregivers.

Sufficient time was considered critical to improving language skills and knowledge of cultural norms and practices of care. A caregiver in Ireland suggested that some time was required to develop better knowledge of the host culture: “[We] just assess what the nurses want us to do first, it’s good for us because we need to listen to how things are being said. And how to understand what they want...because we need to understand what they are talking about, but it takes time for us to understand.”¹⁷ A substantial amount of time was also important to learning about individual patient needs and to the development of an appropriate level of understanding and trust with a client. When caregivers are rushed by various professional duties in care environments, it can be difficult to establish a comfortable rapport between clients and caregivers. An elderly Canadian client considered caregivers to be often hurried by the demands of the job, which negatively affected the ability to be attentive to clients’ needs:

I would say one of the biggest issues is that there’s not enough staff, that they expect the staff to do so much in so short a period of time that even if they wanted to spend just a couple of minutes more trying to understand a patient, they’re required to go off somewhere and make beds or look after another patient because they’ve got 30 patients to look after in a one hour period. I think it’s the ratio of caregivers to patients that is not good.¹⁸

Discrimination can affect the provision of care

Some older people expressed a preference for native-born caregivers because of levels of comfort with shared language and culture, while others expressed curiosity and excitement about interacting with people of different cultures. Race and nationality also affected the way recipients viewed the foreign workers providing them with care, and this led to some discriminatory behaviour. Cases were reported where clients were verbally abusive to migrant caregivers or refused to be cared for by them; 41 per cent of employers in the UK reported that migrant care workers were not always well received by older care users. This presented difficulties for care managers for whom care users were sometimes paying clients, a situation for which some reported receiving little guidance or training.

Some elderly clients referred to an adjustment period with migrant caregivers. An employer in Ireland suggested that older people might need some time to adjust to accepting care from migrant caregivers:

People of 80 and 90, would not have grown up in this kind of an era...that you'd have migrant workers in your organization and I found that it's hard for the resident to accept them... but when they got used to the idea...they accepted them as a part of the staff, they came to like them and appreciate them.¹⁹

Familiarity over time was perceived as potentially leading to greater trust between foreign caregivers and elderly clients. A Zimbabwean care worker in the UK suggested that though there may be preferences for native caregivers, time allows the caregiver to establish trust:

Most clients respect white people. They tend to have more respect and trust in white people. Maybe it's due to cultural things but I personally think that it is a lack of confidence in mostly foreign carers. Until you get to know them, and then until they know you they might start to begin to trust you, but if you just walk into their room, the elderly person will have to find levels of trust.²⁰

Another Zimbabwean caregiver in the UK perceived negative interactions between older people and some migrant care workers to be sometimes due to language barriers rather than discrimination:

If you have, like, people from different nationalities struggling with the English language and they can't communicate with the clients, it's just frustrating in the sense that they might do things that the client doesn't want to have done. But then it's the communication barrier that you have usually. So, it's not maybe that they hate a person, where they are from or anything, but they can't understand each other.²¹

It could nevertheless sometimes be difficult for a manager or care agency to be clear whether hostility was based on genuine communication barriers or prejudice, making it more difficult for them to know how to respond. These problems of discrimination relating to racial or ethnic prejudices are also experienced by native-born workers who do not experience barriers relating to language or accents, indicating a need for measures to address discriminatory attitudes towards migrant care workers and other care workers.

Where difficulties arise because of the preferences of older people, this could present a conflict with the right of the migrant care workers not to be subjected to race discrimination. Discriminatory practices by employers and care users are thus issues that need to be addressed in the sector, although this research could not

establish the extent to which they are widespread. Some employers have attempted to educate care recipients on the principles of non-discrimination and on adjusting to care arrangements with caregivers of different countries of origin, although the findings suggest a need for greater guidance for employers on how to address discriminatory attitudes among clients.

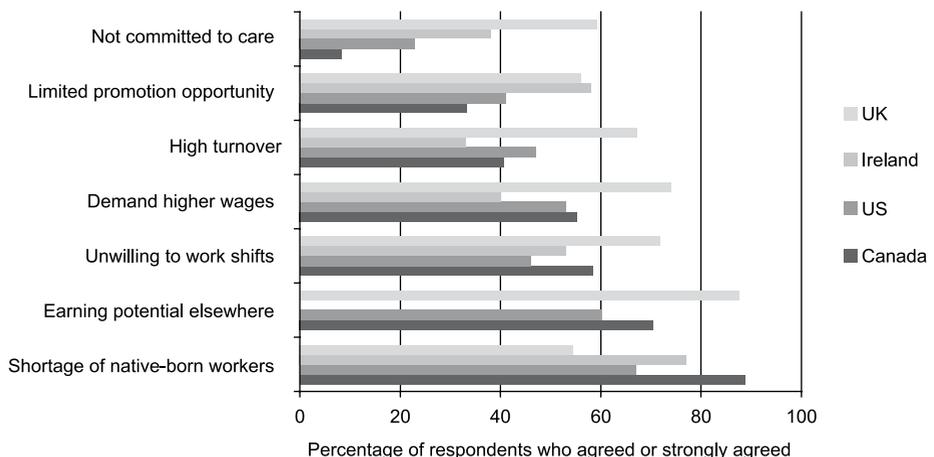
PERSPECTIVES OF EMPLOYERS AND WORKERS ON RECRUITMENT AND EMPLOYMENT

The perspectives of employers, gained through our postal and online surveys of more than 1,500 care providers, including fixed questions and open-ended comments, shed considerable light on challenges in the recruitment and employment of migrant care workers. Additional in-depth interviews with employers and fieldwork with migrant eldercare workers tended to confirm the findings of large-scale surveys that migrant workers are a valued supply of labour with strong work ethic, which, for the most part, outweighs challenges such as language difficulties.

Employers report that native-born workers are hard to find

For a number of reasons, employers who participated in the survey and who were interviewed in all four countries experienced difficulties attracting native-born nurses and direct care professionals to eldercare positions. The leading problem for the vast majority of respondents in Canada, Ireland and the United States was a general shortage of native-born workers qualified for or interested in taking up eldercare positions. Though a majority of the respondents in the UK also found this to be problematic, employers there found that demands for better wages and earning potential posed greater constraints to employing native-born workers. In all countries, preferences for higher-paying jobs, earning potential found elsewhere, and limited potential for promotion in eldercare positions were all cited as factors contributing to native-born workers' disinterest in eldercare positions. Figure 4 shows employer responses regarding problems in employing native-born workers in the eldercare

Figure 4: Difficulties in hiring native-born workers



Source: Surveys of employers.

sector. Both social and professional care settings reported difficulty hiring native workers, but social care hiring also suffers from categorization as lesser-skilled work. One Canadian employer suggested that there was interest in hiring native-born workers, but the interest was not returned on the part of native caregivers. “You know what? We just don’t get the applications. There’s no problem. You know, we’re more than happy to hire but we don’t get the applications.”²²

There was variation across countries among employers with regard to the hiring of native workers. Though employers in Ireland also reported that the shortage of native-born workers was due to lack of interest from native workers in these positions, they also noted the difficulty of recruiting native workers for private nursing homes due to differing benefits between the public and private sectors. Therefore, interest in care positions among native workers was likely to be higher for jobs in the public sector than those in the private sector. One employer in Ireland suggested that the limited benefits offered in the private sector played a role in recruitment. “The private sector finds it notoriously difficult to recruit Irish nurses [and] care assistants as it competes with the public sector, which has more benefits and sometimes higher wages.”

A majority of the respondents in the United States and the UK stated that finding workers with the right skills is a leading problem in employing native workers, with more than 60 per cent of the respondents registering agreement in both countries. Though there has been an upturn in the willingness of native workers to assume eldercare positions, this is likely a temporary effect of the global financial crisis, which has spurred a general willingness on the part of native workers to undertake jobs they might previously have not considered. Canadian employers also commented on the limited interest in eldercare positions on the part of native workers in Canada. The manager of a home care agency in the UK reiterated that hiring native workers was not an issue in terms of recruitment or preference for foreign caregivers. “We don’t specifically go out with the intention of just recruiting migrant workers, it just so happens that we have the majority of them apply to us. So it’s not a case that we heavily recruit migrant people.” When asked about staff shortages, one US employer interviewed suggested that perhaps the high demand for caregivers in their area was driving up the need for foreign-born professional caregivers. “There simply are not enough nurses in our area!”²³

Some of the problems with hiring native-born workers could be attributed to the preferences of potential employees and the unappealing nature of eldercare positions for many native workers. With the exception of the United States (46%), over half of all respondents in the other three nations agreed that an unwillingness to work shifts posed a problem in hiring native workers for eldercare positions that require constant care. An employer in Ireland noted that shift work played a role in the

decision of native care workers to assume positions as elder caregivers: "...a lot of Irish care staff would not be available to work full-time, they wanted to work two days a week, or one day a week or didn't want to work weekends, didn't want to work evenings."

Retaining native-born workers in eldercare positions presents challenges. High turnover was an issue in the UK, where 67 per cent of the respondents agree that turnover of native-born employees is a significant concern. Departure of native staff was also a problem in Canada (40%) and the United States (47%) but less so in Ireland, where only 32 per cent of respondents agreed that native employees leaving was an issue. Native workers' commitment to care was noted as a significant problem in the UK (59%), but it was listed as a significant problem for less than 40 per cent of the respondents in the other three countries. This suggests that there are perhaps cultural determinants or differences in the general approach to elderly care taken by native caregivers. Some evidence of this can be found in the interviews with foreign caregivers and recipients and their assessment of the workplace environment. Irrespective of the disposition of native-born workers toward caring for older people, general shortages in native-born workers can be linked to the conditions of the care positions themselves, such as poor pay and working environments, low prestige, and lack of career development.

Recruitment for professional care varies in intensity

Local recruitment of migrants who already live in the host country is the first option for many eldercare settings. Employers in the UK and Ireland are often required by law to conduct resident labour market tests and advertise vacancies locally before applying for work permits. Finding local workers is faster and less expensive than international recruiting and obviates the bureaucracy of immigration procedures and regulations. Local migrant communities can also provide deep, informal networks for valuable word-of-mouth recruitment. Though many employers expressed preferences for informal networks and direct recruitment of eldercare workers, many also noted the benefits of engaging formal recruitment agents as a means of locating high-quality eldercare workers.

Recruiting agencies for professional caregivers and nurses are fairly common in Ireland and the UK. Recruiters are less common in Canada, perhaps due to their points system or a more permeable immigration system, and the United States. However, the US recruiting landscape has changed in recent years with the growth of a substantial number of new recruiting agencies. Across all four countries, these advantages were, of course, balanced out by some negative sentiments, as respondents did indicate that there were mixed results from utilizing recruitment services. One Irish eldercare

employer commented on the mixed potential of engaging recruitment agencies. “We have had some excellent, extremely competent workers employed via recruitment agencies. We have also experienced completely inappropriate placements causing extreme difficulty in the work place.” Figure 5 presents employers’ opinions on the advantages of using recruiting agencies.

Figure 5: Advantages of using recruitment agents



The management of the bureaucratic aspects of attracting and employing foreign workers was widely seen by respondents as the most critical benefit of using recruitment agencies. Many employers confirmed their desire to shift the procedural aspects of employing formal workers to specialized agencies. An overwhelming majority of respondents in Ireland and the United States (90%) acknowledged that leaving paperwork to outsourcing agents and recruiters was an important factor in an employer’s decision to contract with these organizations, with strong responses from the UK (79%) and Canada (70%). These agencies allow employers to focus on aspects of care and the provision of quality services and obviate the need for conducting extensive research on current legislation and maintaining and ensuring legal status for all employees. An Irish employer noted the important service recruiters played in simplifying the hiring of foreign-born workers: “Helpful, informed on changing recruitment laws. Anxious to keep paperwork efficient.”

Where standard methods of recruitment are also problematic, employers noted that specialized agents have an important role. More than 60 per cent of the respondents in each country stated that the difficulties associated with normal recruiting methods were a key factor in the decision to engage outsourcing and recruiting agents. This

was particularly true in Canada (85%) and the United States (73%). One employer in the UK commented on the need for formal agents and the potential for long-term, reliable use of their services:

Over the last 10 or 12 years, it has become more and more difficult to fill the vacancies and so, about three years ago, you'd get the odd flyer through the door from agencies, to say that you can get staff, and that's the route we took. We made contact with an agency and that agency initially furnished us with two Filipino girls and that seemed to work well and that's the route we continued on. In fact, we stayed with the same agency right the way through.²⁴

In Canada, these services were seen as particularly useful in attracting nurses to eldercare positions. More than 82 per cent of the Canadian employers surveyed said that these agents were helpful in locating nurses, compared to just over half of the respondents in other countries noting this as an advantage of using an agency. This was also seen in Canada as a benefit to hiring direct care or lesser-skilled workers; this sentiment was shared by respondents in the UK (57%), but this was not a significant factor in the United States and was not reported in Ireland.²⁵ One Canadian employer discussed the need to resort to agencies as a result of a limited supply of nurses within the native population. "We can't get registered nurses casually. The work force is substantially depleted and we do use agency nurses when forced to."²⁶

Canadian and Irish employers contacted for this survey also felt that utilizing recruitment agencies tended to guarantee higher-quality employees and that those agencies largely ensured that ethical standards and hiring practices would be followed. Fewer respondents in the other two countries shared this latter attitude toward recruiters, with quality employees outscoring the increased likelihood of ethical standards. A minority of the employers in all four countries agreed that using recruitment agents was a cheaper alternative to direct methods. This implies that though there may be increased costs associated with outsourcing and recruitment agents, there are some important benefits that justify the higher costs.

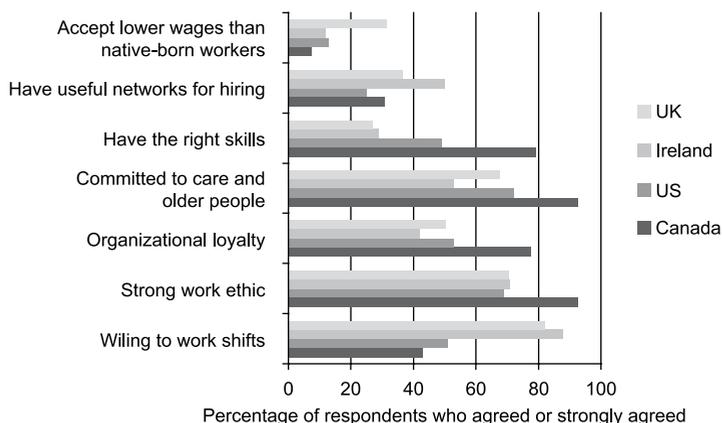
Migrants have a "good work ethic" and are compassionate

Employers in the eldercare sector responded that once workers have been hired, there are a number of distinct benefits to employing migrant workers for eldercare positions. Figure 6 highlights the key advantages that employers found to employing migrant workers in the eldercare sector. Though networks and some compensation advantages present themselves to employers, it was the professional and personal qualities of foreign-born workers that most appealed to employers.

The “strong work ethic” of foreign-born workers was cited as an important advantage by over two thirds of all respondents across all four countries. In Ireland, almost 90 per cent of all respondents reported that foreign workers were willing to work all shifts. Similar results were reported in the UK (80%), with slightly more than half citing this willingness in the United States (51%) and less than half (43%) citing it in Canada. As eldercare workers are typically needed to staff round the clock, for many of the caregivers this is an important factor in the appeal of foreign workers. In the UK, 75 per cent of the respondents also cited a willingness to learn new skills as a benefit of employing foreign-born workers. Some respondents expressed the opinion that migrant workers tended to value their jobs more and, as a result, worked harder than native employees. Other employers noted that foreign-born workers are willing to do tasks or jobs that native workers do not want to or refuse to do. In the UK, a residential care manager praised the work ethic and good nature of foreign-born eldercare workers. “[Migrants] are more punctual. They don’t take time off without genuine cause. They’re more willing to do extra work if it’s available; you know, just generally they’re polite and...friendly.”²⁷ Evidence from migrant caregivers suggests caution in attributing a stronger “work ethic” to foreign staff, as they may be willing to accept poor working conditions because of financial constraints or their immigration status.

A commitment to caring for the elderly and loyalty were largely viewed as positive aspects of employing migrant workers. Across all four countries, more than half of the respondents reported that foreign-born workers are committed to caring and are respectful of elderly clients. This was particularly true for the United States and Canada, where 72 per cent and 93 per cent of the respondents, respectively, agreed on the high level of care and commitment from migrant workers. Roughly half of

Figure 6: Advantages of hiring migrant workers



the respondents also stated that foreign employees were loyal to organizations and employers. This opinion was expressed somewhat more strongly in Canada, with 78 per cent of employers underlining this advantage of employing migrant workers. Both of these factors were thought to be due to cultural norms carried over from the migrant workers' home country. One US home care employer noted a cultural predilection for care and nurturing among Filipino caregivers. "Because of the traditional belief that children take care of their elderly emotionally and financially and continuing generations of family take care of each other, nurture, and support each other, Filipino caregivers stand out as far as elderly care is concerned."²⁸ This sentiment was shared by a number of employers in all countries, who felt that caring for the elderly was a cultural norm respected by many of the foreign workers they employed.

Having the appropriate skill sets was reported as an important asset of foreign workers in Canada and, to a lesser extent, in the United States. These skills could be related to professional care or soft-skill sets. Nearly 80 per cent of the respondents in Canada and half of the respondents in United States found this to be true of foreign-born workers, while this was true for less than a third of the respondents in Ireland and the UK. Many employers distinguished between the appropriate professional skills required for and related to eldercare and language skills or knowledge of the host country's cultural norms.

Having the right professional skills saves the employer and the employee unnecessary delays in the process of hiring and training eldercare staff. Proficiency in English and a solid understanding of the cultural norms surrounding elderly care were also viewed as key qualities for foreign caregivers, as this knowledge lends itself to establishing trust and respect with employers, clients and fellow caregivers.

Some foreign-born caregivers bring with them access to a larger, informal network of nurses, professional caregivers, and direct caregivers. Increased access to informal networks of eldercare professionals or potential candidates for these positions is viewed as an important bonus to employing foreign-born workers. Accessing these networks saves employers a substantial amount of time and money in the recruitment process and brings an increased level of comfort to the immigrants employed by these organizations. Respondents in Ireland (50%), the UK (37%) and Canada (31%) replied that having networks that make hiring easier was a distinct advantage of hiring foreign workers, with just 25 per cent responding that this was a recruiting factor in the United States. In interviews, many suggested that the benefits of informal networks were seen more in the recruitment of direct caregivers than in the recruitment of nurses or professional caregivers, where local and regional recruitment agencies play a larger role. Recruiters are rarely used to staff direct care

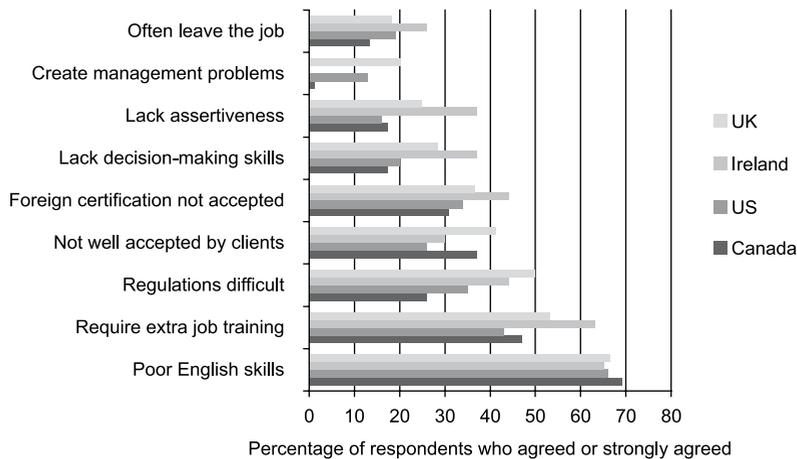
positions, as foreign-born workers tend to find these positions through informal networks and traditional means of advertising.

Employers did not report that foreign-born workers will accept lower wages than native workers for the majority of respondents in all four countries. With the exception of the UK (31%), fewer than 20 per cent of employers responding in the other three countries agreed that foreign labour comes at a cheaper price than home-grown labour. In fact, empirical analysis of data from the United States indicates that foreign workers earned a higher wage than native workers in the eldercare sector. This surprising result could be attributed to foreign-born eldercare workers taking on more hours than native workers. Some employers have suggested that foreign-born workers also tend to enter the eldercare workforce with higher levels of education and certification than many of their native counterparts.

Challenges of hiring migrant workers

There are also numerous challenges when it comes to employing immigrants in eldercare positions, as evidenced by the factors presented in Figure 7. Many respondents commented that problems related to the skill sets of arriving foreign-born caregivers are of primary concern. Employers across all four countries noted that difficulties communicating with caregivers are a challenge to working with foreign-born workers and having them work with elderly clientele. Roughly two thirds of respondents across countries agreed that poor English skills could be a significant challenge when employing immigrants. Some immigrants face a steep learning curve when adjusting to host countries and limited English skills can compound the problem. In addressing these “softer skills”, some report that a lack of cultural awareness created problems for caregivers and recipients. Though generally not reported in other countries, in Ireland 68 per cent of the respondents stated that the lack of Irish cultural knowledge was problematic. In addition to learning and understanding host-country speech and culture, foreign workers must often learn new methods and technologies to perform in new working environments. This can create additional challenges for foreign workers to interact with both employers and the clients for whom they provide care.

Figure 7: Challenges of hiring migrant workers



One home care worker in the United States commented on the challenges foreign pronunciation and English ability pose to elderly clients. “Limited English knowledge and heavy accents make communication with elderly clients with hearing deficiency complicated. Strong accents can make teaching difficult with elder, hearing-impaired patients.”²⁹ A Canadian eldercare employer expressed a similar concern, indicating that when foreign-born workers use their native language to communicate with co-workers, it can create distance between foreign-born caregivers and their clients and native-born co-workers. “If, for example, they’re using their foreign tongue when they’re on the premises, that’s not good. That alienates other workers and, uh, it’s just not appropriate ’cause English is the language that’s spoken here. So that would probably be the most difficult part of things.”³⁰

Beyond language, other worker attributes posed challenges for employers using migrant workers. Sometimes the adjustment to a new care system required foreign workers to undertake necessary job training or perhaps gain new or additional certification. With the exception of the United States and Canada, where 43 per cent and 47 per cent of respondents agreed, respectively, more than half of the respondents stated the requirement of additional training as a disadvantage to employing foreign workers. Personal skills, such as decision-making skills and assertiveness, appeared as problems across countries but in varying degrees. The lack of decision-making skills was reported by less than one third of all respondents in Canada, the UK and the United States, while this problem was reported by 38 per cent of Irish respondents. Thirty-seven per cent of the respondents in Ireland maintained that assertiveness was a problem in working with foreign employees, while 25 per cent of the respondents in the UK, 17 per cent in Canada and 16 per cent in the United States cited this as a problem.

An additional challenge was the attitude of some non-migrant care workers towards their colleagues – a management issue which some employers felt ill-equipped to handle – and the fact that migrant caregivers were not always well received by older adults, with more than one in four employers in each country citing that as an issue. In other cases, however, older care users were appreciative of the migrants who cared for them.

A number of bureaucratic hurdles create additional difficulties in the employment of foreign-born eldercare workers. Regulations complicate the process in the UK, where 50 per cent of all respondents listed this as a constraint to taking on foreign-born workers. More than 40 per cent of the respondents in Ireland agreed with this assessment, while 35 per cent agreed within the United States and 26 per cent agreed in Canada. Roughly one third of all respondents in the four countries found that the acceptance of foreign labour certification standards is a problem when bringing in foreign-born workers, with slightly more than 40 per cent of the respondents in Ireland reporting that this factor complicated the hiring process.

High turnover rates, which were largely viewed as a difficulty in retaining native workers in eldercare positions, do not pose difficulties of the same magnitude for foreign-born workers. These workers tend to remain with an employer, with less than 25 per cent of all respondents reporting this as a problematic aspect of employing immigrants. This could be due to the strong networks that form among immigrant groups coming from the same nation or region, keeping them with the same employer. Some employers noted that sponsorship of foreign worker visas binds the worker to the sponsoring employer, which almost guarantees a specified length of employment.

Caregiver perceptions on recruitment

During interviews and focus group discussions, migrant caregivers offered perspectives on various aspects of their employment in eldercare. Some interviewees had prior experience or background as health-care professionals. Others saw work in eldercare as a stepping stone to better-paying health jobs or an important temporary stage for foreign-born caregivers pursuing additional training, certification, or other educational opportunities. Direct elderly care positions present low barriers to entry into the labour market, allowing migrant workers with limited English ability or incomplete education to attain work in the host country. Some caregivers also had difficulties in making the transition from working in their native country to positions in direct or professional care in the host country. As previously discussed, migrant workers in eldercare positions reported experiences of discrimination by employers in recruitment and remuneration.

It can be expected that all high-skilled caregivers and nurses have had prior experience in health care with certification or equivalent qualifications. Interviews and data across the four countries indicate that the majority of lesser-skilled caregivers had a strong background or certification in health-care positions as well. Some of these caregivers certified in professional care in their home country were able to work in professional care positions, while others accepted temporary or transitional positions in lesser-skilled jobs. Some of the qualified migrant care workers stated that having credentials or experience in their native country was irrelevant in the host country if they are not allowed to practice their skills. This presents a number of issues for foreign-born workers in the delivery of care. Foreign-born professionals may be forced to take under-employment in lesser-skilled positions as they await credentials and certification. They may also have to refrain from treating patients with some treatments or medicines as it may present legal or regulatory constraints.

Some caregivers interviewed had extensive experience and credentials in their native country as nurses or professional caregivers, but had yet to receive their credentials or licences in their host country. While caregivers prepare for testing, certification, and licensing, direct care positions serve as temporary positions on the road to professional caregiver and nursing positions. Whether migrant caregivers had professional qualifications prior to arrival in the host country or were attempting to obtain these qualifications for the first time, workers interviewed across countries suggested that social care posts help fill employment gaps. One Canadian employee explained his willingness to work in direct care positions as a necessary means to an end:

Once the licence [for physiotherapy] comes in then it will be opening up... Right now it's just kind of going through the phase. And at the beginning as I mentioned tomorrow if I didn't work, if I didn't do this work, I get my license and I apply for the job they won't give me the job because they will say 'You don't have Canadian work experience.' So this is just to fill Canadian experience right now as an assistant.³¹

Some workers reported that they found work in eldercare positions because it was an easy means of obtaining solid employment in the host country. In Ireland and the UK, migrant eldercare workers acknowledged that they had entered into lesser-skilled positions in eldercare because it was the first job they obtained and it was simply a source of employment. In all countries, direct care positions are considered lesser-skilled jobs, thereby presenting lower barriers to entry that can provide an attractive employment option for newly arrived foreign-born workers. Foreign-born caregivers in Ireland and the UK reported seeing frequent postings for direct care positions. Other caregivers expressed that they had found the job through friends

or family members, suggesting that these workers maintain informal community networks that guide contacts to social care positions.

Some interviewees stated that discrimination can begin at the screening process for eldercare candidates, most often in the form of bureaucratic delays or non-responses from employers regarding application status. One African caregiver in Ireland spoke about the apparent distinction between the criteria for African workers to obtain a job, as compared with those for EU nationals:

Where I worked first... they ask you what qualifications do you have? Do you have this certificate, do you have this? Then other people [EU nationals] who come in, they don't have anything, no certification, no qualification, and they just take them in. Whereas we're the ones with the certificates, I mean if you have those people beside you, and you are looking for the same job, you just forget about us, we just forget all about the certificate, because they would prefer to take the [EU national].³²

The example mentioned may not be an explicit preference but rather a result of EU policies regarding labour mobility. For some foreign-born workers, the discrimination was not identified as directed specifically at any nationality or race, but merely a matter of preference for working with other native caregivers.

CONCLUSION AND RECOMMENDATIONS

This report presents the comparative results of a research project on the role of migrants in the workforce of caregivers for the elderly in the UK, Ireland, Canada and the United States. As noted, the purpose of the study was to examine current and future demand for migrant care workers in ageing societies and the experiences of employers, migrant care workers, and older people. The context in all four nations is one in which funding has been, and will increasingly be, constrained, whether the source is private or public. Indeed, most of the central challenges raised by the use of migrant labour are embedded in the context of what is, essentially, an often-underpaid sector of employment. Our overarching conclusion is thus that the solutions to the challenges we identify lie fundamentally in the social care system. The increasing reliance on recent migrants can be seen as a symptom of the structural and funding challenges social care systems are experiencing, and migrants, while they have a contribution to make, are not the solution to those deficiencies.

To address the immediate challenges that our research identified, we suggest that policies affecting employment relationships should be prioritized. For example, employers should stress the benefits of migrant workers and claim not to pay migrants less than native workers. At the same time, this is a low-wage sector which, employers also report, fails to attract natives, and our findings suggest issues relating to migrants' working conditions that need to be addressed. Employers' preferences may be shaped by the fact that their "good work ethic" effectively means that migrants do the job on the employer's terms, that they are willing to work hours and shifts which other workers often resist. Migrants' loyalty to the organization may, in no small part, be because they are bound to the employer because of their immigration status – temporary work visas, in particular, keep migrants tied to their sponsoring employer. Furthermore, it can be hard to disentangle statements about migrants' care ethos from stereotypes about certain nationalities, say preferences for Filipina workers (Anderson and Ruhs, 2008; Waldinger and Lichter, 2003). In other words, our research suggests that employers perceive migrants positively, but the reverse side of those perceptions may reflect the sometimes less-than-favourable working conditions reported by workers themselves.

These conditions signal what should be significant concerns about the working conditions of many migrant workers in long-term care, as well as concerns about what they mean for the continuity and quality of care of older persons. We found that migrant caregivers already play a substantial role in all four countries and the demographic shift toward older populations, coupled with changes in domestic labour supplies, is likely to generate latent demand for more migrant caregivers in the future.

Given the low wages in the long-term care sector and the ageing of today's eldercare workforce, the supply of native workers may be further depressed. That possibility will likely be bolstered given recent policy and funding trends – except perhaps in Ireland – toward the provision of low-wage care in home-based settings, which, in turn, generates challenges that are exacerbated for the migrant workforce. Migrant caregivers have strong footholds in care environments, particularly in less-regulated areas such as care in home-based settings. The more informal the setting, the lower the worker's earnings, the greater the likelihood of migrant employment, and the greater concern there is for abusive working conditions and threats to the quality of care. The supply of migrant labour is welcome when it supports care for the older population, especially if domestic supply is limited. However, the policy emphasis should be on working conditions and quality of care, not simply on increasing the supply of migrant labour.

With little exception, migrant admission policies in all four nations have tended not to cater to older adult care workers. Skilled nurses and physicians in the past tended to have relatively ready access to legal admission in all four nations – often, but not always, in visa classes designated generically for highly skilled workers – but these regular classes of admission for skilled employment have supplied rather few migrants in long-term care per se. Care workers admitted through labour migration channels for skilled workers have been more prevalent in Ireland and, to a lesser degree, in the UK than in the United States or Canada. Increasingly restrictive criteria introduced in recent years (mainly high-wage threshold requirements), though, have made it more difficult to recruit care workers from outside the European Economic Area. In terms of labour migration avenues for lesser-skilled care workers, only Canada has a temporary admission class for migrants who live in homes as social caregivers. This is a significant programme, reviewed in the Canadian report of this project, but not without problems of oversight typical of home settings with the potential for abuse, which have only begun to be addressed in recent reforms (Bourgeault, 2010). That programme is both an exemplar for other nations, as well as a caution to those contemplating expanded temporary work visas for long-term caregivers.

The high percentages of migrants in lesser-skilled care occupations across all four nations suggest that a large proportion of these workers have been admitted outside the labour migration channels. Lower-skilled social or direct care workers are, for a substantive part, initially admitted in family or humanitarian classes of admission. The UK and Ireland receive a substantial supply of often temporary labour in social care from the new EU members, especially Poland. On the other hand, the United States stands out with about one fifth of its direct/social care workforce being unauthorized, even though the impression that unauthorized workers in social care

are less common in other nations cannot be verified without equivalent statistical estimates. Overall, two things seem clear: first, the current admission systems in all four nations supplied substantial numbers of foreign workers to long-term care, as seen in migrants' significant percentage of the sector's workforce; and second, problems with legal temporary work programmes, unauthorized workers, and agreed-upon methods of determining labour shortages, however, signal significant challenges to managing that supply going forward.

Once in the workplace, the fieldwork and surveys in all four nations found that most employers agree that migrants are hard-working and compassionate employees who are reliable and responsible caregivers. A significant number of employers suggested that the quality of care had improved through the employment of migrant care workers. There are, however, distinct challenges to the employment of migrant caregivers. Employers, caregivers and the elderly all noted that language and communication issues underscore the challenges of migrant caregivers. Knowledge of English and the ability to recognize and respond to various dialects remains the most frequent source of difficulty for all parties, although cultural knowledge and sensitivity in the delivery of care can be obstacles that persist despite levels of language ability. Language issues play a part in the recruitment process too, as some employers appear to struggle to find workers through traditional direct hiring methods.

Hiring and recruiting migrant workers raises different types of issues. Most hiring for in-country migrant caregivers is done through informal means. Though some migrants find employment through direct means, word of mouth is the common form of recruitment among migrant communities, providing cost advantages for the employer and work environment benefits for the migrant communities. These migrant networks function across the skill spectrum, but perhaps especially for lower-skilled social caregivers. Nurses generally tend toward more formal channels of job location, such as recruiters, employment agents, and certification boards. Among higher-skilled workers, the use of professional recruiters by employers is more widespread. While this appears to be somewhat less commonplace in the United States than in the other countries, the use of recruiting agencies for professional caregivers is also on the rise in this country. On the one hand, recruiters have clear benefits because they can identify skilled workers who are not as tightly integrated into migrant networks and they reduce onerous migration paperwork. On the other hand, the cost of recruiters can be high, deterring their use. In all four nations, the use of recruiters raised concerns about distancing the ultimate employer from the selection process and ethical practice in commitments made to migrant workers.

While our data do not provide evidence of the extent of discrimination in the recruitment and hiring of migrant workers, prejudice and discrimination clearly occur in the workplace and can have significant consequences. Less-favourable working conditions than those for native workers were reported by some of the migrant workers in this research, including unfair treatment by employers relative to natives, with employers scheduling work on the weekends, in longer shifts and at lower rates of pay for migrant workers. Tension may exist with native co-workers as well. Differential treatment by employers calls for active policies against discriminatory practice.

By and large, the elderly tend to praise migrant caregivers for the quality of both the health and social care they provide, as well as their dedication. Migrant caregivers also generally report friendly and even familial relationships with the older people for whom they care. However, tensions can exist, in some cases due to: language and cultural differences and difficulties in communication, lack of sufficient time for care workers to develop relationships with older people, or the discriminatory attitudes of some older people. Discrimination in this respect can be difficult for employers to address, given their obligations to meet the needs and preferences of their elderly clients and to ensure the rights of their employees. The importance placed by older people and by migrant workers on their relationships suggests that attention should be given to: facilitating those relationships, language and cultural sensitivity training, and allowing adequate time for communication as central to the quality of care. Overall, the fieldwork, surveys, and interviews suggest that older people are less concerned about the ethnic characteristics of caregivers than they are about the quality of care they receive from them.

Recommendations

The policy challenges fall into four broad domains. First, the migrant care labour market is in need of increased attention related to recruitment, skill requirements, admissions, mobility, and residency issues. Secondly, the migrant care experience must be addressed in terms of the attitudes and expectations of employers and clients, the training required for foreign-born workers, and the discrimination that pervades some of the sector. Employment policies may need to recognize the issues unique to migrant workers in the long-term care sector, in order to protect and improve their working conditions or enhance their skills to provide quality care. Thirdly, employment policies may need to seek improvement of jobs in the sector generally, either through training, regulations on earnings and working conditions, or other means of ensuring quality care for the elderly, and to attract or retain natives in the care sector. Finally, migrant admission policies, which tend not to target older adult care workers, may need reform to better integrate older adult care policymaking with

that for migrant workers. While no single effort can completely map out all of the possible policy ramifications, or spell out in detail prescriptions for priorities, the findings of this project leads to the following list of recommendations.

Meeting the future challenges of long-term care

Employment conditions for the social care workforce should be improved to address recruitment challenges.

- Relying on migrants to fill gaps may not be the best solution to care worker shortages; rather, improved status, earnings, and better career pathways and working conditions are the best means of attracting and retaining workers.
- Initiatives to address public perceptions should be developed, promoting the importance of eldercare and tackling the perception that eldercare is a job limited to women and low-skilled workers.
- As the number of elderly continues to rise, it is critical for legislators in all countries to prioritize eldercare within national budgets in order to meet increasing needs for long-term care, and to encourage review of current policies and standards. Care worker shortages have a negative impact on the capacity of the sector to meet demand for care services, the quality of care and the working conditions of all care workers.

Improving the working conditions of migrant care workers

Working conditions for migrant care workers should be improved and continually monitored. Admission-side policies should regulate their hiring, and training should be an integral part of skill upgrading.

- Discrimination towards migrant care workers should be combated. The research findings show clear evidence that discrimination exists and includes the favoured treatment given to natives by employers in terms of shifts and hours of work and in the treatment of migrant workers by older people. Means of monitoring discrimination should be facilitated – for example, through the procurement of care services. Access to information and advice on employment rights and means for redress should be facilitated for migrant workers and for employers regarding their responsibilities and how to resolve any conflict of rights between older clients and migrant workers.

- Many workplace tensions could be resolved with cultural sensitivity training of workers, employers and clients. Booklets on best practices and information sessions could be made available to each stakeholder in order to address common misinformation and encourage mutual understanding.
- Special efforts need to be made to monitor home care. In all four countries, the regulations in place for institutional settings often do not apply to homes or less-formal care settings. External intermediaries should be brought into the process to ensure that the direct employment of migrant workers in the homes of older people meets the requirements of labour standards and that the quality of care also meets appropriate standards.
- Regular statistics on migrants in long-term care should be collected whenever possible to provide data on the migrant workforce and to monitor employment status and working conditions. In the United States, for example, census surveys since 2000 have collected detailed occupational and industry characteristics, along with migrant ethnicity and country of origin. Yet, a special sample of workers in nursing homes includes a question about migrant status while the nation's survey of nurses does not. Admission data or professional certification data are other sources of information that should include details on migrant status.

Improving the training of care workers for older people

Language provision and access to ongoing training in social care should be improved to ensure professional standards. Staff ratios and shifts should allow for adequate time to be allocated to developing care relationships with older people.

- Access to language training should be improved. Language skills are fundamental to the provision of care to older people. Employers should play an important, voluntary role but policymakers can identify funding and means of facilitating language training for those employed in care of older people.
- Recruitment practices should be monitored to ensure that professional standards of qualification and certification are sufficient for all workers in the eldercare sector.
- There should be increased training for all care workers. Social care workers, in particular, are required to have little training, which can create care challenges and reinforces low earnings. Guidelines for training should be developed or promulgated and should include provisions for language and cultural awareness training.

- There should be updated regulations for caregiving in long-term care institutions and particularly home care. Regulations for home-based care are necessary to protect older people and their carers.

Coordination of long-term care and immigration policies

There is little evidence from our study that admission of migrants in long-term care should be a priority, but future employer demand should be closely monitored.

- Better coordination is needed between the government departments/agencies responsible for care provision and those responsible for immigration control.
- Where shortages of caregivers can be identified, special admissions may be an option. The process of identifying “shortages” and assigning appropriate admissions goals differs significantly in each national setting. Appropriate steps, therefore, will vary, but not without first addressing quality-of-work issues for existing workers.
- Temporary migrant work programmes may not be a preferred solution, given the importance of continuity of care and the acquisition of strong language skills and cultural competency:
 - The Canadian LCP suggests that temporary programmes may under-employ workers relative to their skills, as many sectors tend to do with migrant workers. Temporary work programmes also leave migrants dependent on their employer. At the least, temporary programmes should permit workers a lengthy enough stay to provide continuity of care, but also permit workers to move between employers to combat dependence and potential exploitation. This latter recommendation echoes the call for visa “portability” between employers.
 - Durations of stay for temporary workers should take into account the desirability of permitting lengths of time sufficient to provide continuity of care for older persons.
 - The regulations and requirements permitting transitions to permanency should be transparent and, when permitted, should be known at the outset and facilitated administratively.

- Admission guidelines and paperwork should be improved. In all countries employers report that they turn to recruiters to ease paperwork requirements for hiring migrant workers, strongly suggesting a need to streamline regulations and procedures.
- The commonplace use of recruiters calls for their regulation, either with voluntary codes of conduct or, if it appears to be necessary to avoid widespread abuse, by government agency. There should be regular evaluation of the recruitment industry.

Care work is an international market and, therefore, the EU and international organizations should consider the important role they can play in the coordination of policies on long-term care and migration, and in the regulation of recruitment processes at the international level. The World Health Organization recently released the Global Code of Practice on the International Recruitment of Health Personnel, an important first step in addressing these issues.

ENDNOTES

1. The term native-born is used here reflecting its common use in current migration literature, e.g. an individual born in the country of reference.
2. The term foreign-born worker is used for migrant workers born outside of the country of reference who may have arrived at any time and who may or may not have a background in health and social care.
3. Information on the older clientele was not collected in the United States.
4. As discussed elsewhere, Canada has a programme specifically designed to import live-in caregivers for the elderly. Also, the Ministry of Health and Long-Term Care (MOHLTC) has released a resource kit for the long-term care facility operators that outlines tips and strategies that target professionals for recruitment to rural communities, among others, and to recruit immigrant groups. Note, nevertheless, that the Live-in Caregiver Program was designed for both child care and long-term older adult care.
5. Although the introduction of the new points-based immigration system in the UK has now drawn attention to the determinants of labour shortages in relation to the need for migrant labour in the UK economy (Anderson and Ruhs 2008; MAC, 2008) and in the care sector specifically (Moriarty, 2008).
6. The current requirements of Canada's LCP include: a job confirmation letter from a Canadian employer, a written contract with the employer, successful completion of an equivalent Canadian secondary school education, at least six months' training or at least one year of full-time paid work experience in the past three years, good knowledge of English or French, and a work permit before entering Canada. Live-in caregivers can later apply to become permanent residents of Canada.
7. Female Indian nurse, Phoenix, Arizona,
8. Nursing home, urban Minnesota.
9. Female Polish care worker, referring to experiences of working in a nursing home.
10. Results were not reported for the UK.
11. BC care recipient 2.
12. Irish care recipient.
13. Male participant, prospective user, UK.
14. Female Zimbabwean live-in care worker.
15. Ontario Care Worker J2.
16. BC care recipient 1.
17. IN/KW/04/G.
18. BC care recipient 3.
19. Irish care recipient.

20. Male Zimbabwean care worker, home care.
21. Female Zimbabwean care worker, residential home.
22. BC employer.
23. Nursing home, urban North Carolina.
24. Manager of a home care agency, London.
25. Irish data was not collected for this and not reported in the graph.
26. BC employer 4.
27. Manager of a residential care home in south-east UK.
28. Home care, rural New York.
29. Home care, suburban Maryland
30. Ontario employer 2.
31. Ontario care worker 13, assistant for physiotherapy in a long-term care facility in Ontario.
32. IN/DC/02/G, interview subject.

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APPENDIX 3: COUNTRY REPORTS

Canada

Bourgeault, I. et al.

2009 *The Role of Immigrant Care Workers in an Aging Society: The Canadian Context and Experience*. University of Ottawa, Ottawa.

Ireland

Walsh, K. and E. O'Shea

2009 *The Role of Migrant Care Workers in Ageing Societies: Context and Experiences in Ireland*. Irish Centre for Social Gerontology, Galway.

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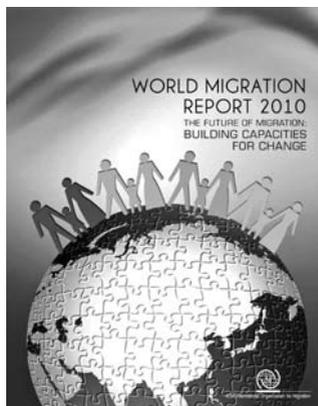
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All reports are available on the project webpage:

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World Migration Report 2010 - The Future of Migration: Building Capacities for Change



Migration is a constant and dynamic phenomenon increasingly requiring diversified policy intervention in order to maximize its potential benefits and minimize related costs for both countries of origin and destination as well as migrants themselves. Better knowledge and enhanced capacities in different policy areas are essential to ensure the protection of migrants, the facilitation of legal migration, the integration of migrants into the country of destination, the support for sustainable voluntary return and the greater interlinking between migration and development.

The challenge remains in translating improved understandings into policy and practice on the ground. State capacities around the world for managing migration are limited. Legal frameworks may need to be updated or overhauled to focus on new areas of migration, or to handle new influxes or outflows of migrants; staff working on the front line may need equipment, training and support; civil society and migrants themselves may not be adequately integrated into the process of data-gathering and making and implementing policy; vulnerability factors and health risks inherent to the migration process need to be better understood and addressed.

International migration is likely to transform in scale, reach and complexity, due to growing demographic disparities, the effects of environmental change, new global political and economic dynamics, technological revolutions and social networks. These transformations will be associated with increasing opportunities, exacerbate existing problems and generate new challenges.

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The ageing of the population presents serious challenges to developed Western nations, particularly those managing the retirement and care of a growing number of older persons. The ageing population will generate an increasing demand for caregivers, a demand made challenging because of the declining availability of native-born caregivers compounded by various factors including declining family care of older people, increasing life expectancy of infirm elderly and the increasing demand for social caregivers, often in home settings. Health care institutions and long-term care facilities have been turning to the foreign born to address shortages of workers, reflecting a parallel trend in the migration of health care workers worldwide. Indeed, migrants already play a significant role in the care of older persons.

This report presents the comparative results of a research project on the role of migrants in the workforce of caregivers for the elderly in the United Kingdom, Ireland, Canada and the United States. The purpose of the study is to examine 1) the contextual factors influencing current and future demand for care workers in an ageing society, particularly migrant care workers; 2) the experiences of migrant workers, of their employers, and of older people in institutional care (residential and nursing care homes) and in home-based care; 3) the implications of the employment of migrant workers in the care of older people for the working conditions of the migrants concerned and for the quality of care; and 4) the implications of these findings for the future care of older people and for migration policy and practice.



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