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“We Shall Travel On”: Quality of Care, Economic Development, and the International Migration of Long-Term Care Workers

by

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EXECUTIVE SUMMARY

I. Introduction—Long-Term Care Workforce: A Crisis in the Making?

The theme of the Filipino Nurses’ Hymn, “We shall travel on,” was meant to inspire newly trained nurses to travel to remote locations to bring health care services to underserved regions of the country (Choy, 2003). But the phrase has taken on new meaning as increasing numbers of nurses have left the Philippines, with their government’s encouragement, for employment in the United States, the Middle East, and the European Union. In recent years, 70 percent of nurse graduates in the Philippines have “traveled on” to other countries, joining an army of more than 15,000 nurses who leave the country each year (Bach, 2003). Similar scenes are playing out in India, China, sub-Saharan Africa, the Caribbean, Eastern Europe, and the Pacific Islands as tens of thousands of nurses, aides, and domestic caregivers leave their homelands each year to work in more developed countries. The overwhelming majority of these workers are women, and many end up providing long-term care services to the aging populations in developed countries.

This report examines demographic, social, and political factors driving the increased international migration of workers to provide long-term care services in developed countries. These factors affect the availability and quality of long-term care services in the developed countries, as well as the availability of health care services and the economic development of the developing countries that are the source of these workers. The report raises policy questions with which individual countries, as well as international organizations concerned with the needs of both developed and developing countries in our complex and changing world, must deal.

But the international migration of long-term care workers is not just a national or international issue. Some of the most compelling issues are played out in the lives of individuals who make the difficult decision to leave their homelands, their families, and their ways of life to seek opportunity in a new land—and the individuals with disabilities whose lives they touch and support. International agreements and national policies that do not deal with the aspirations and needs of both the persons with disabilities and their caregivers are doomed to failure.

II. Purposes

The purposes of the report are to:

1. outline factors that shape international labor markets for long-term care workers, including demography, skill levels, gender and race, and historical and geographic relationships;

2. describe how policy decisions regarding long-term care financing, immigration, credentialing, and recruitment affect long-term care labor markets;

3. provide brief snapshots of how international labor markets affect the provision of long-term care in select developed countries;
4. report patterns of migration among health and long-term care workers from developing countries and the effects of this migration on the provision of health care and economic development in those countries;

5. summarize how the growing use of international workers affects the quality of long-term care services and outline policy decisions that may affect quality; and

6. examine in depth the use of foreign-born workers in long-term care settings in the United States, included in Appendix B.

III. Methodology

While a complete picture of the international migration patterns of long-term care workers is not possible, this report uses three methods to piece together what we can learn from existing data and what gaps still exist in our knowledge.

- The first is a review of the disparate literature on migration patterns, the demography of developed and developing countries, and international comparisons of long-term care systems and immigration policies.

- The second method involves analyzing data compiled by international and national organizations, such as the United Nations Population Division, the Organization for Economic Co-operation and Development (OECD), the National Council of State Boards of Nursing, and the Council of Graduates of Foreign Nursing Schools.

- The third method is to conduct original analyses of trends in the employment of foreign-born nurses and nurse aides in long-term care settings in the United States, using U.S. Census and American Community Survey data.

IV. Demographic, Economic, and Social Factors Shaping International Labor Markets and the Migration of Long-Term Care Workers

Part IV examines the demographic, economic, and social factors shaping international labor markets for long-term care workers in developed countries, including:

- **Demographic Trends**—The demographic challenge to developed countries is twofold: 1) an aging population requiring more long-term care services, and 2) a diminishing supply of workers to fill the jobs associated with long-term care. In the two oldest nations, Italy and Japan, the number of people age 80 and older is projected to more than triple, from 5 percent to nearly 17 percent by 2050; however, the number of working age people (age 15–64) is projected to decline by 38 percent during that period.

- **Skill Levels and Working Conditions?**—As part of more general trends affecting health and long-term care, the demand for workers is at both higher skill levels (e.g., skilled nurses) and lower skill levels (e.g., nursing home aides and home care assistants). In 2004, the United Kingdom (UK) and the United States each licensed more than 15,000
new internationally trained registered nurses. These nurses represented 44 percent of the new nurses in the UK and 15 percent of new nurses in the United States.

- **Gender and Race**—Migrating women from racial minority groups provide increasing amounts of long-term care in several developed countries. The proportion of foreign-born nurses in U.S. long-term care settings who are white declined from 45 percent in 1980 to 18 percent in 2000; during the same period, the proportion of black nurses increased from 16 percent to 30 percent, and that of Asian nurses increased from 29 percent to 38 percent.

- **Historical and Geographic Relations**—Migration often follows historical patterns of former colonies to colonial powers (e.g., the Philippines to the United States) or geographic proximity (e.g., Hungary to Austria). Between 1998/99 and 2003/2004, the proportion of foreign-trained new registered nurses who came from developed countries in the European Union (EU), Australia, New Zealand, the United States, and Canada declined from 72 percent to 19 percent—with the offsetting increases coming from the Philippines and former British colonies in Asia and Africa.

V. **Policy Decisions and the International Migration of Long-Term Care Workers**

Policy decisions also play a major role, intentional and unintentional, in the volume and patterns of international migration to provide long-term care. Part V evaluates the impact of policy decisions in the following areas:

- **Long-Term Care Financing Policies**—Public policies on long-term care financing reflect and reinforce service delivery models and traditions of family responsibility, which affect the demand for various types of international workers. The proportion of older people in institutions ranges from 2.2 percent in Italy to 7.9 percent in Sweden.

- **Immigration Policies**—Even in the face of demographic challenges, most developed countries have been reluctant to open their doors to more immigration, especially to unskilled workers. Japan has some of the most restrictive immigration policies with the result that only 110 foreign “medical service” workers (doctors and nurses) worked in the country in 2003.

- **Education and Credentialing**—In addition to addressing quality issues, education and credentialing requirements can be a method for limiting the admission of long-term care workers, especially nurses. Of 19,903 nurses who began the process of applying for the U.S. prescreening exam in 2003, only 3,482 received visa screen certificates; slightly more than half of these nurses could expect to pass the licensing exam on the first attempt.

- **Worker Recruitment**—Selective recruitment, formal and informal, also shapes the migration patterns of long-term care workers, especially among skilled nurses. Despite a code of ethics restricting the recruitment of nurses from certain countries, one of every
four overseas nurses who were qualified in the UK in 2002–2003 were from countries on the Department of Health’s proscribed list.

VI. Snapshots of Migration and Long-Term Care Workers in More Developed Countries

Part VI explores how the factors shaping international long-term care labor markets are experienced in specific developed countries receiving the workers. These countries were chosen because they represent different approaches to long-term care financing and immigration, which have resulted in different patterns of worker migration.

• Japan—Japan has some of the most pressing demographic needs but still has very restrictive immigration policies. In a recent survey, 83 percent of Japanese respondents opposed increased immigration by foreign workers.

• Scandinavian Countries—Sweden and Norway fund a substantial array of home-based and institutional services, mostly provided by public agencies, with small but growing numbers of foreign-born workers employed in long-term care. The OECD reports that 19.3 percent of the foreign workers in Norway and 20.3 percent of those in Sweden work in the “health and other community services” sector, the highest percentages reported among OECD countries.

• Italy—The combination of a strong tradition of care by families and friends, changing roles of women, and a modest cash benefit financing system has fueled a huge demand for home care workers in Italy to augment family caregiving. Roughly half a million low-skill and mostly undocumented international workers provide supportive services to older people in their homes.

• Austria—One of every eight people in Austria (12.5 percent) is foreign born, slightly higher than the 12.3 percent in the United States, which is generally thought to be more open to immigration. Substantial cash benefits, little regulatory oversight, and a tradition of home care have encouraged substantial use of international long-term care workers in Austria, many of whom are illegal but are openly recruited by agencies for short-term, rotating care duty.

• United Kingdom—The UK is one of the largest importers of professional health care workers in the world, a large percentage of whom work in the long-term care system. The number of newly registered nurses from Africa quadrupled between 1998/99 and 2003/2004.

• United States—The number and percentage of foreign-born workers in U.S. long-term care settings have increased substantially, especially in central cities where more than one of four nurses and aides is foreign born. Overall, the proportion of foreign-born workers in long-term care settings rose from 6 percent in 1980 to 16 percent in 2003.

VII. The Migration of Long-Term Care Workers and Countries of Origin: Brain Drain or Pathway to Development?
Part VII examines factors driving international long-term care labor markets from the perspective of the source countries. Often, the economic and professional incentives to migrate from the perspective of individual workers may create problems for the health care systems of their home countries. Short-term effects can also be quite different from long-term effects. The complex issues related to migration from the perspective of less developed countries include:

- **Skill Levels—Brain Drain or Transfer of Skills?** Whether the movement of health care professionals is a “drain,” a “strain,” or a “gain” depends on at least three factors: 1) the number of health care workers a source country has compared to its health needs; 2) the percentage of the skilled workforce that migrates; and 3) the patterns of migration from and return to less developed countries. Many sub-Saharan African countries have fewer than 20 nurses per 100,000 population, compared to more than 1,000 in Norway and Finland.

- **Economic Impact—Route to Development or Loss of Investment?** The net effects of immigration on economic development are not uniform or entirely clear. Remittances are an important source of revenue to developing countries, but they also come at the expense of the loss of workers who are better educated and at the peak of their productive years. Estimates of income from remittances, much of which comes from health care workers, are roughly the same as estimates of total gross domestic product (GDP) in Samoa and Tonga.

- **Education—Raising or Lowering Standards?** Migration has had both positive and negative consequences for the quality of nurse education. Some nurses are taught to international standards so that graduating nursing students can pass licensing exams in other countries. But in some countries, such as the Philippines and India, the quality of the new nursing schools created to meet increased demand is uneven.

- **Gender—Liberation for Women or a New Dual Labor Market?** In 2000, women represented 51 percent of migrants in more developed countries, but only 45 percent of migrants in less developed countries. Nursing continues to provide professional opportunities and personal liberation to women from less developed countries, but exploitation is distressingly common as well.

- **Integrating Foreign Long-Term Care Workers—Professional Enhancement or Discrimination?** Integrating migrating nurses and aides can be a major challenge for employers and workers. Discrimination based on race or foreign-born status from clients, fellow professionals, and administrators is reported frequently.

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**VIII. How Is the Quality of Long-Term Care Affected by the Use of International Workers?**

The degree to which international workers improve the quality of services or create problems is a very complicated question—involving multiple policy objectives and definitions of “quality.” Part VIII outlines the limited evidence regarding quality and international workers and raises policy issues that must be addressed.
• *Is Immigration the Best Way to Address Worker Shortages?* To the extent that international workers relieve the stresses of staffing shortages, they can be one part of a strategy to improve the quality of care, but many countries will have to deal with tough questions related to increased immigration.

• *How Can Public Agencies Be Sure that International Workers Are Qualified?* International workers compare reasonably well on many measures of quality, but assuring that the migrating workers are able to do the work is a continuing concern.

• *How Can Developed Countries Meet the Demand for Unskilled Workers?* Most long-term care work is done by unlicensed, low-skill workers. Quality measures are likely to focus increasingly on care from unskilled, often illegal workers.

• *How Do Cultural and Linguistic Differences Affect Quality of Care?* Prejudice and cultural preferences can be obstacles to successful caregiving relations, raising questions about “cultural competence” and management practices to ease the transition to a new culture.

• *Do Migrants Depress Wages and Undermine Working Conditions?* From the perspective of unions and professional associations, employing foreign workers undermines efforts to improve wages and working conditions for nurses and aides. The evidence is mixed; foreign long-term care workers are more likely to take jobs in less desirable locations, but they earn more on average than their native-born counterparts.

• *What Responsibility Do Developed Countries Have for the Impact on Source Countries?* Importing large numbers of health care workers to work in long-term care settings can have negative consequences for the source countries, but different solutions are required to address the specific situations in the countries losing such workers.

**IX. Conclusions**

Meeting the long-term care needs of the older populations in more developed nations, as well as the economic development and health care needs of less developed nations, will require more engagement across international boundaries. The quality of the long-term care received by older persons in developed countries will depend increasingly depend on the quality of the engagement with the less developed countries that are likely to supply more of the workers in the future. An array of policy options, programs, and international arrangements will have to be flexible and tailored to fit the very different needs of each country. Policies and programs that address perceived needs at the national and international levels cannot ignore the individual needs and aspirations of both those who need long-term care and those who would provide that care.