INTERNATIONAL FORUM ON

LONG-TERM CARE

DELIVERING QUALITY CARE *with* A GLOBAL WORKFORCE

OCTOBER 20, 2005 | WASHINGTON, DC, USA

CONFERENCE PROCEEDINGS

AARP® Global Aging Program

WE WILL NOT REACH A LEVEL OF ADEQUATE CARE IF WORKERS CONTINUE TO VIEW LONG-TERM CARE AS A STOP-GAP POSITION OR A SECOND JOB, OFTEN THE LOW RUNG ON THE LADDER.

JENNIE CHIN HANSEN,

AARP Board Member

TABLE OF CONTENTS

Executive Summary 3

Opening Remarks 9

Keynote Address 10

AARP Research: International Migration and Long-Term Care 14

Panel I: Integrating a Multinational Workforce 19

Luncheon Address: Searching for Solutions 26

Panel II: Financing and Attracting a Long-Term Care Workforce 30

Panel III: The Changing Delivery of Long-Term Care 38

Looking Ahead 47

Conclusions and Emerging Issues 47

LADAN MANTEGHI WELCOMES PARTICIPANTS TO
THE CONFERENCE ON LONG-TERM CARE WORKFORCE.

EXECUTIVE SUMMARY

DELIVERING QUALITY CARE WITH A GLOBAL WORKFORCE

In recent years many countries have found it increasingly difficult to attract and retain long-term care workers. The shortage has driven developed countries to look toward developing nations as a source of long-term care providers, raising a variety of emerging economic, ethical and policy issues for debate.

- Is immigration the best way to address worker shortages?
- What responsibility do developed countries have for the impact of migration on source countries?
- Do migrants depress wages and undermine working conditions?
- How do cultural and linguistic differences affect the delivery of quality of care?
- How can foreign-born workers be integrated into long-term care work settings?

On October 20, 2005, the AARP Global Aging Program hosted an international forum in Washington, DC, to begin exploring these critical questions. In conjunction with the conference, the AARP Public Policy Institute released a new report that examines trends and patterns of international migration in long-term care workforces. The report and other conference materials are available at www.aarp.org/ltcforum.

Addressing the Shortage

Developed countries across the world are experiencing a dramatic increase in their older populations. However, the gift of longevity is raising sharp concerns about how to provide care for this growing demographic.

In Japan and Italy, two of the oldest countries, estimates show there will be three older people for every four working-age citizens by the middle of the century. A recent AARP report revealed that, in the United States, the population of adults age 85 and older is projected to more than double by 2030. Meanwhile, the traditional caregiving population, women age 20 to 54, is expected to increase by just 9 percent.

The way each country addresses its aging society is shaped by its long-term care financing system, tradition of caregiving and views on immigration. In Norway and Sweden, for example, substantial public spending has resulted in a largely native workforce. The United Kingdom, in contrast, is one of the largest importers of professional health care workers. Similarly, in the United States, immigrants account for 40 percent of the nursing workforce.

Countries with cash-benefit approaches, such as Italy and Austria, have focused on informal arrangements with lower skilled workers to supplement family caregiving. Many of these workers are undocumented, but they are openly recruited by agencies.

Virtually every developed country faces the challenge of how to integrate foreign-born workers into their domestic labor force and larger society. Questions also persist about how cultural and linguistic differences impact quality of care.

EXECUTIVE SUMMARY

A Source of Controversy

As developed countries struggle to find the optimal approach to addressing workforce shortages, source countries face their own set of challenges, most notably the phenomenon of "brain drain." The situation is particularly critical in Africa, which bears 25 percent of the world's burden of disease but has only 0.6 percent of the world's health care professionals. Many sub-Saharan African countries have fewer than 20 nurses per 100,000 population, compared to more than 1,000 in Norway and Finland.

The emigration of health professionals not only represents a human resource loss, but it has financial implications as well. Estimates from the United Nations Conference on Trade and Development reveal that each migrant health professional means a loss of US$184,000 to Africa, which spends over US$4 billion a year on the salaries of foreign health experts.

While "brain drain" is unquestionably a major concern for Africa, other source countries view the exportation of workers as an important economic strategy. Workers from India sent back an estimated US$23 billion in 2004, and the Philippines received over US$8.5 billion in official remittances. However, although emigration provides financial benefits to these countries, the impact on quality of care is unknown.

Responsible Recruitment

In evaluating whether the movement of health care professionals is a "drain, a strain or a gain," it is important to consider three criteria: the number of health care workers a source country has compared to its health needs; the percentage of the skilled workforce that migrates; and the extent to which workers return to their country of origin.

To advance the potential for win-win situations, some countries have begun experimenting with bilateral labor migration agreements. The goal of these agreements is to tailor the numbers and types of health care workers and training requirements to the needs of both the source and destination countries.

Ethical international recruitment must not only take into consideration national goals, but the needs of individual workers as well. Over the past five years, a boom in the recruitment industry has resulted in a disturbing rise in fraud and abuse. More must be done to protect international workers throughout the recruitment and licensure process.

Host countries also must recognize that international workers and their families will need help with housing, transportation and social integration into communities. Many female workers not only face the challenge of adapting to a new language and culture but also must cope with a major shift in household gender roles. The degree of transition supports available is key in determining whether these women can be successful in their new positions.

Quality at Home

Even when international recruitment is pursued responsibly, it should not be viewed as a catch-all solution. Developed countries must cultivate a domestic labor force by enacting policies that will make long-term care a more attractive profession. Investments are needed to increase wages, improve benefits and provide opportunities for career advancement and training in long-term care.

Technology may play a valuable role in mitigating the workforce crisis as well. Japan and North Korea already are developing robots to assist with daily activities such as bathing and cooking. In the United States, there is growing excitement about the use of sensors to passively monitor older adults and reduce paperwork for caregivers.

Tomorrow's solutions could stem from even more out-of the-box thinking. Some experts have gone as far to suggest that developed countries will eventually export older adults instead of importing caregivers. While this idea may seem farfetched, people in developed countries already travel to Thailand, India, South Africa and Cuba to receive high-quality, less-expensive medical services.

OPENING REMARKS

JENNIE CHIN HANSEN DISCUSSES HER PERSONAL EXPERIENCES IN DEALING WITH INTERNATIONAL WORKERS IN A LONG-TERM CARE SETTING.

OPENING REMARKS

Confronting the Global Demands

Long-term care workforce issues highlight the extent to which countries are interdependent and interconnected, emphasized AARP Board Member Jennie Chin Hansen, in her opening remarks. Advances in science and technology are promoting longevity, but also creating new caregiving challenges that are compounded by changing family dynamics.

The long-term care workforce presents an immediate and growing problem for many countries that already face worker shortages and high turnover rates. Ms. Hansen challenged participants to consider how first rate care can be delivered, calling for improved training standards, higher wages and better working conditions. "We will not reach a level of adequate care if workers continue to view long-term care as a stop-gap position or a second job, often the low rung on the ladder."

Reflecting on her experience as executive director of On Lok, a community-based model of care, Ms. Hansen stressed the value of providing workers with support, education, career mobility and adequate compensation. Using these principles, she was able to achieve a turnover rate of 12 percent among On Lok's 600-person staff, two-thirds of which were foreign-born workers.

In addition to cultivating a domestic base of workers, many countries will need to look abroad to meet growing demand. Ms. Hansen touched on current trends and the diversity of approaches being tested in different European countries, such as the cash-benefit systems driving the use of undocumented home care workers in Italy and Austria, and the more formalized overseas recruitment taking place in the United Kingdom.

While developed countries grapple with the best way to address workforce shortages, source countries face their own set of challenges. Africa bears 25 percent of the world's burden of disease but has only 0.6 percent of the world's health care professionals. Many sub-Saharan countries have fewer than 20 nurses per 100,000 population.

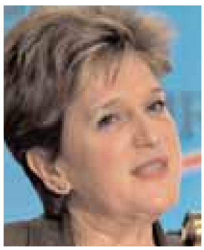
In evaluating whether the movement of health care professionals is a "drain, a strain or a gain" on developing countries, Ms. Hansen urged the consideration of three factors: the number of health care workers a source country has compared to its health needs; the percentage of the skilled workforce that migrates; and the extent to which workers return to their country of origin.

Developed countries need to invest in developing, training and retaining both native and foreign-born workers. More training is needed for current workers, and providers must learn to incorporate new technologies. However, Ms. Hansen stressed, "The human component—the touch of the hand, the kind word, the strong arm to support the frail body—remains critical to successful and compassionate care."

Ms. Hansen closed by pointing to the importance of international arrangements to address the needs and aspirations of those who require long-term care and those who would provide that care. She raised a number of questions, such as whether increased immigration is the best way to address worker shortages, what responsibilities developed countries have for the impact of immigration on source countries, and how culture and linguistic differences affect quality of care.

THE BREAKDOWN OF BORDERS

Countries should not try to stop or restrict the movement of health care professionals, but rather manage that movement in a way that benefits all partners, challenged Danielle Grondin, M.D., director of migration health for the International Organization of Migration, in her keynote address. "The mobility of people is a fact of modern life, bringing both new opportunities and challenges."



DANIELLE GRONDIN explains the changing demographics in global migration patterns.

It is estimated that migrants now represent about 2.9 percent of the global population, and the actual number is likely higher taking into account the number of undocumented residents. Economic incentives are high for people to migrate to industrialized countries, which are seeking to fill workforce gaps with labor from developing countries.

Mobility patterns have changed substantially over the last 50 years, Dr. Grondin noted. While international migration was traditionally unidirectional and permanent, today's patterns are much more complex. A given country may at the same time be experiencing immigration and emigration, and the journey of workers may be permanent, temporary or seasonal.

A major concern for developing countries, particularly those in Africa, is "brain drain," which has both financial and health consequences. Each health care professional who emigrates from Africa represents an estimated loss of US$184,000 to the continent.

Dr. Grondin discussed some of the approaches being tested to mitigate the "brain drain" phenomenon. The United Kingdom, for example, has devised a code of practice for ethical international recruitment that bans employers from actively recruiting from developing countries unless an agreement has been made between the two governments. The code also seeks to provide protections for workers who immigrate.

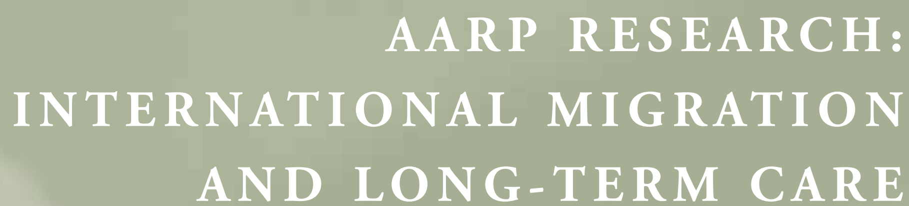
A second potential solution is bilateral agreements that involve the temporary exchange of health care professionals to fill respective gaps. The United Kingdom has such agreements in place with South Africa and Ghana. Dr. Grondin also noted that some developing countries, such as the Philippines, voluntarily train and export health care workers as part of a national economic strategy.

Industrialized nations face their own set of challenges. In most countries, health care workers are moving from rural to urban areas and do not return to the under-served areas. Many health care professionals are also leaving the field altogether resulting in "brain waste."

Dr. Grondin urged developed countries to do more to retain their native workers and also called for better treatment of both documented and irregular immigrants. "It takes courage to migrate," she said, noting that many of these workers lack access to the very health care systems in which they serve.

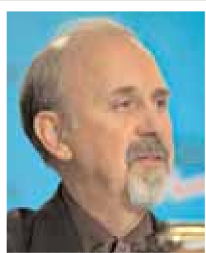
The migration of health care workers will continue, but international recruitment should not be viewed as a quick fix, Dr. Grondin stressed. "Solutions cannot be sought in isolation, confined within an individual country's borders alone, but must be considered at a global level, which will take into consideration both the health care providers and the users of health care in the world."

"Solutions cannot be sought in isolation, confined within an individual country's borders alone, but must be considered at a global level, which will take into consideration both the health care providers and the users of health care in the world."


AARP RESEARCH:
INTERNATIONAL MIGRATION
AND LONG-TERM CARE

AARP Senior Policy Advisor Donald Redfoot, Ph.D., presented an international report from the AARP Public Policy Institute, "We Shall Travel On: Quality of Care, Economic Development, and the International Migration of Long-Term Care Workers." Patricia Pittman, director of AcademyHealth Programs, moderated this research presentation. The AARP international report, prepared by Dr. Redfoot and Ari N. Houser, is available on www.aarp.org/ltcforum.

International Migration and Long-Term Care



DON REDFOOT releases his findings of "We Shall Travel On", a report from the AARP Public Policy Institute.

New types of engagement are needed between developed and developing countries to address the global aging phenomenon and related workforce issues, Dr. Redfoot stated, reflecting on a new AARP study that examined factors driving the migration of long-term care workers. "The quality of long-term care older persons receive in the more developed countries may increasingly depend on the quality of engagement with less developed countries that are likely to supply more of the workers in the future."

Industrialized nations are struggling with a shortage of health care workers driven, in part, by demographic factors such as an aging population and low fertility rates. In Japan and Italy, two of the oldest countries, there will be three older people for every four working-age people by the middle of the century. Developing countries, in contrast, are characterized by large working-age populations, making them a prime source of potential workers.

There are three labor markets related to long-term care, Dr. Redfoot noted, and each has its own distinct patterns. The high-skilled market tends to be global, while the lower-skilled market is more regional. The third market is composed of irregular immigrants who provide a substantial percentage of home care in some countries.

Dr. Redfoot emphasized that gender and race are playing a significant role in transforming the caregiving workforce. As women in developed countries have achieved greater status in the workplace, fewer have chosen to enter traditional professions like nursing; at the same time, the shift from an industrial economy to a service-driven economy has created new opportunities to empower immigrants and women of color. Historical and geographic relations also influence migration patterns, with many countries looking at former colonies as potential sources of labor.

In the policy arena, migration patterns are driven by four key areas: long-term care financing, immigration, education and credentialing, and worker recruitment. The way these factors interact in each country reflects the diversity of approaches to addressing an aging society.

Long-term care financing policies are important in establishing demand for different types of workers, Dr. Redfoot explained. In Norway and Sweden, for example, substantial public spending has resulted in a largely native workforce that is well paid and highly trained. Conversely, countries with cash-benefit approaches, such as Italy and Austria, have focused on informal arrangements with lower-skilled workers to supplement family care.

With respect to immigration policy, the Organization for Economic Cooperation and Development has noted three trends: a general toughening of policies to control migration; more international coordination to control irregular migration patterns; and selective policies that have emphasized the migration of high-skilled workers.

Education and credentialing are a way to achieve quality, but they can also be used to limit access. Workers migrating to developed countries often experience "de-credentialing" when they arrive. Dr. Redfoot noted that there is much talk about the potential for international standards that would promote mutual recognition among different countries.

There are also a number of issues surrounding the largely unregulated business of international recruiting, Dr. Redfoot observed. Ideally recruiters should serve as guides for employees and migrant workers, but criticisms have arisen about misrepresentations and ethical concerns surrounding the "brain drain" of source countries. Some organizations have put forth ethics codes, but the effectiveness of these codes is limited because there is no means for enforcement.

"The quality of long-term care older persons receive in the more developed countries may increasingly depend on the quality of engagement with less developed countries that are likely to supply more of the workers in the future."

Dr. Redfoot called for further research in developed countries to inform policy decisions regarding long-term care delivery, the integration of foreign workers, and consequences of various approaches to financing and immigration policy. Research in developing countries might look at successful strategies for developing long-term care systems and reintegrating workers who have spent time abroad.

It is essential to consider the diversity of migration patterns, Dr. Redfoot closed, emphasizing that no one solution will fit every country. He added, "Policies and programs that address needs at the national level cannot ignore the individual needs and aspirations both of those who need long-term care and those who would provide that care."

Discussion

The issue was raised as to whether standards should be internationalized and if such a move would have a positive impact in the trade arena. Citing India as an example, Dr. Redfoot commented that many countries are beginning to teach to the tests of developed countries. He went on to say that, while economists generally suggest the greatest efficiencies come from open labor markets, in this case it wouldn't be mutually beneficial unless developed countries invest in source countries to mitigate "brain drain."

Dr. Redfoot also was asked to share more information about the international recruitment industry. He reiterated that recruiters can play a valuable role both to migrating workers and employers by helping them prepare and guiding them through the process; however, he s tressed that the industry is diverse and unregulated, which has led to problems.

PANEL I

SUZANNE WEISS, AN EXPERT FROM THE AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, OFFERS HER THOUGHTS REMARKS ON THE STATE OF THE LONG-TERM CARE WORKFORCE.

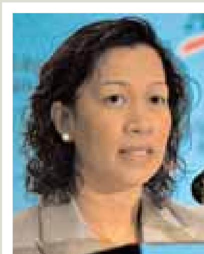
PANEL I

INTEGRATING A MULTINATIONAL WORKFORCE

Patricia Pittman, director of AcademyHealth Programs, moderated the first of three panels.

Human Resource Capital: The Philippine Experience

With 4 million of its citizens working in 188 countries, the Philippines is regarded by many industrialized nations as a key source of human capital. The country's Overseas Employment Program, launched in 1974, has become a model for how to train and deploy a global workforce, explained Assistant Secretary of Labor Maria Anthonette Velasco-Allones.



MARIA ANTHOETTE VELASCO-ALLONES shares the Filipino policy framework used to help manage the recruitment, training and deployment of workers.

Like many developing nations, the Philippines has a large and growing pool of young workers. Yet the country currently lacks the capacity to generate enough local jobs, leading to unemployment and underemployment. These factors, coupled with the increasing demand for health care workers in developed countries, have led many Filipinos to seek employment opportunities abroad.

A 2002 survey from the Philippine Nurses Association stated that there were 27,000 nurses employed locally and 170,000 employed overseas. Between 1998 and 2000, more than 24,000 health professionals migrated to other countries, and nurses constituted the largest percentage of this group.

Over the last decade, the Filipino government has advanced its policy framework to help manage the recruitment, training and deployment of workers, Assistant Secretary Allones said. The Higher Education Act of 1994 created the Commission on Higher Education, which regulates institutes of higher learning. Another key development was Republic Act 7796, which created the Technical Education and Skills Authority, resulting in the formation of national skills standards for caregivers.

With respect to foreign recruitment, Assistant Secretary Allones explained that Filipino workers are deployed through three tracks: private recruitment, "name for hire" schemes, and government-to-government agreements. The country has 12 existing bilateral agreements and negotiations pending with 22 other countries.

Assistant Secretary Allones emphasized that the government has taken steps to protect workers abroad. The country has 34 overseas labor offices and its Overseas Workers and Welfare Administration manages a welfare and training fund for migrant workers.

While the Philippines benefits from foreign remittances and upgraded training, the strategy of exporting workers is not without challenges, Assistant Secretary Allones acknowledged. The deployment of workers has created a strain on local health care systems, particularly those in rural areas. There is also the added cost of training workers to international standards, as well as the health risks these workers incur abroad.

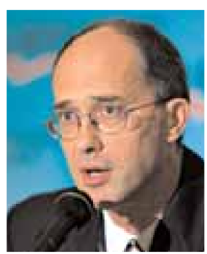
> "Health human resource development in the light of present global demographic concerns will be one of the defining issues of our time."

Assistant Secretary Allones cautioned that the Philippines is experiencing its own difficulties recruiting nurses. From 1995 to 2000, there was a decline in the volume of graduates from medical and related fields, with the downward trend being attributed to a decreasing number of nursing graduates.

To counter this trend, the Philippines is instituting reforms in health care financing and the management of medical and education nursing and services. In the future, the country may try to reverse some of the migration of health workers from the Philippines by boosting its retirement industry through incentives like dual citizenship and by marketing the country's affordability and climate.

Assistant Secretary Allones called for international sharing of human resources policies and a multi-country policy research agenda to promote health human resources development. She closed, saying, "Health human resource development in the light of present global demographic concerns will be one of the defining issues of our time."

Informal Caregiving Arrangements: The Italian Case



ROBERTO LAMURA shares the Italian experience of informal long-term care and the role international workers play in this system.

With an aging population and low fertility rates, Italy faces one of the most daunting demographic challenges in the world, stated Giovanni Lamura, Ph.D., a senior researcher with the Italian National Research Centre on Aging. These factors, coupled with the entry of more women into the workforce, have resulted in growing demand for informal home care workers to supplement family caregiving.

Italians' preference for informal home care workers is a natural outgrowth of their views on caregiving responsibilities and their country's cash-benefit financing system, Dr. Lamura explained. While 80 percent of people in Sweden feel it is the state's responsibility to care for older people, most residents of Italy, Spain and Austria believe that the responsibility should rest primarily with the children.

The expense of formal long-term care and shortage of domestic workers have made the employment of irregular immigrants an attractive choice for families. Many of these workers come from Romania and Albania, and others are from former African colonies or Latin America. "Migrant workers have become a fundamental pillar of the Italian long-term care system," Dr. Lamura said.

Over the past five years, the percentage of home care and personal assistant workers from other countries has rapidly increased. Migrant workers now comprise approximately 83 percent of home care workers. These foreign-born workers come and go freely and typically work within the gray economy.

Dr. Lamura acknowledged that it is difficult to measure whether foreign-born caregivers adversely or positively affect the delivery of care. However, the increase of unlicensed, foreign-born caregivers has raised concerns over quality.

Another issue is the potential economic hardships that foreign-born workers face when they have no official status with the Italian government.

In addressing these concerns, Dr. Lamura argued the focus should be on "interaction" rather than "integration," since most migrant workers say they would eventually prefer to return to their native country. He called for increased international cooperation, which would lead to a more organized recruitment and training process and the promotion of regular working conditions.

Dr. Lamura emphasized that Italy also must focus on making caregiving for older people a more attractive profession for native-born Italians. He believes that Italy should allow more students to enter nursing school and provide incentives for older nurses and caregivers. "The way we take care of frail elderly is a primary indicator of the ability of our society to share its resources, both within and across national borders."

"The way we take care of frail elderly is a primary indicator of the ability of our society to share its resources, both within and across national borders."

India: Challenges and Opportunities

With a population of 1.1 billion and a liberal policy toward migration, India is emerging as a key source country for health care workers, explained K. R. Gangadharan, managing director of Heritage Hospital in India. In 2004, Indian nurses accounted for more than 20 percent of newly registered nurses from overseas in the United Kingdom.

K.R. GANGADHARAN speaks of Indian long-term care workers and their preferance to work in non-native countries, like the US or UK.

"Migration is the outcome of a balancing act," Mr. Gangadharan said. He observed that Indian nurses often migrate in search of better career prospects and working conditions. Social norms in the country are also changing, and many young people are expressing a desire to travel.

The issue of "brain drain" appears to be less of a concern for India, which has a burgeoning labor pool and growing number of nursing schools. There were 1.2 million qualified nurses in 2000, Mr. Gangadharan noted, and he estimates more than 40,000 are being trained each year. He stressed that many nurses who migrate return in three to five years, bringing with them experience and training.

India also benefits financially by serving as a labor source. The International Monetary Fund reported that India ranks first in foreign exchange remittances, which increased from 2 billion in 1990 to 12 billion in 2000.

While emigration has been viewed largely as a positive force in India, there are still a number of concerns. When the international recruitment industry began to boom, many workers were taken advantage of by fraudulent agencies.

Even when dealing with legitimate recruiters, workers typically find the visa and licensing process to be rigid and time consuming. There also are cultural pressures for women who migrate, Mr. Gangadharan observed, since few opportunities exist for their spouses.

"People are courageous to migrate, especially to a country where the culture is different."

Indian nurses are often reluctant to work in long-term care settings, since old age homes in India are primarily for the destitute. They may also be unprepared for the paperwork-driven health care systems of countries like the United States.

The issue of greatest concern to Mr. Gangadharan is the racism experienced by Indian workers abroad. "People are courageous to migrate, especially to a country where the culture is different," he stressed. "The receiving country has a moral obligation to prepare for these workers and welcome them."

Mr. Gangadharan closed by stressing the value of Indian nurses, citing their language skills, work ethic and community caregiving experience. He predicted that migration and medical tourism would continue to increase, particularly as standards become more global.

Discussion

The discussion focused on the shortage of nurse educators in the United States, and whether other countries were facing a similar issue. Mr. Gangadharan did not foresee that India would have a problem producing educators, suggesting that countries like the United States may one day import professors of nursing in addition to nurses. Dr. Lamura commented that Italy is in the process of trying to elevate recognition of nursing care by making it a degree.

With respect to the situation in the Philippines, Assistant Secretary Allones acknowledged that, while the country has a proliferation of nursing schools, questions remain about the qualifications of educators. She noted that the Commission on Higher Education is conducting policy initiatives to monitor and ensure that standards for nursing educators are met.

The issue of private sector ventures also was raised. One corporation, for example, is offering Internet training for nurses in rural areas, and then allowing these nurses to complete clinical practices in their hospitals. Nursing schools also are being set up in the Caribbean to train Americans who are closed out of schools in the United States.

PANELISTS REACT TO QUESTIONS ON INTEGRATING A DOMESTIC AND FOREIGN-BORN WORKFORCE.

LUNCHEON ADDRESS: SEARCHING FOR SOLUTIONS

LUNCHEON ADDRESS: SEARCHING FOR SOLUTIONS

LUNCHEON ADDRESS: SEARCHING FOR SOLUTIONS

SHEBA GEORGE shares the personal experiences of her mother who came to the US from India as a nurse.

"Migration is not only about the single, independent immigrant, but rather includes relationships and obligations to families and communities," explained Sheba M. George, Ph.D., author of "When Women Come First—Gender and Class in Transnational Migration." She stressed that each of these factors profoundly affects caregivers' ability to integrate into their countries of destination and, more specifically, their workplaces.

In her luncheon address, Dr. George shared the results of her three-year ethnographic study that explored the migration and settlement process of her mother and other Indian nurses who emigrated during the 1960s. She conducted her research in an immigrant Indian community in the United States and in the Indian State of Kerala, from where the nurses originated.

"Migration is not only about the single, independent immigrant, but rather includes relationships and obligations to families and communities."

The nurses in Dr. George's study immigrated to the United States and established themselves before bringing their families over. This was a huge challenge for these women, who came from a society where traditionally women do not even travel alone. Once their families arrived, they faced additional complicating factors, such as the fact that many of their husbands ended up in jobs that were of less status and lower pay.

Dr. George emphasized that, in addition to overcoming the expected challenge of migrating, the nurses and their husbands had to deal with dramatic changes in gender and class relations. In the immigrant Christian congregation where these nurses belonged, "nurse husbands" were stigmatized as emasculated lower class men.

There was also a stigma against the nurses themselves, who were viewed as "loose" and "dirty" women. Upon traveling to Kerala, Dr. George learned that the Indian community found nursing scandalous because women had to touch and clean the bodies of male patients. Nurses were also assumed to be from lower class origins, because of the "menial" nature of their work.

Dr. George emphasized that the nurses' conceptions of nursing work from India shaped their experiences in the United States. In addition, while the nurses faced difficult but expected challenges in getting their licenses, they were not as prepared to deal with racial discrimination by patients, other providers, and administrators. Several nurses in the study commented that they did "real" nursing work while the native nurses "got away" with just charming and sweet-talking the patients.

Despite the many challenges they encountered, the nurses found new empowerment in their vocation as patient care managers, teachers and consultants. Their experiences in India allowed them to retain a sense of vocation in the face of racism, but also to appreciate the positive, empowering aspects of work in the United States.

“Global workers represent far more than their credentials alone and can be placed under tremendous strain by the circumstances of their migration,” Dr. George reiterated. She urged employers and recruiters to consider instituting programs that would help the spouses of global workers find adequate employment.

“Global workers represent far more than their credentials alone and can be placed under tremendous strain by the circumstances of their migration”

More can be done to improve relations between global workers and their native peers, Dr. George added. Global workers not only need help preparing for licensing exams, but need help understanding cultural, linguistic and historical sensitivities as well. Likewise, native workers need training on how to interact with global workers. Such expressions of concern for the worker would likely promote quality of care.

PANEL II

FINANCING AND ATTRACTING A LONG-TERM CARE WORKFORCE

Suzanne Weiss, senior vice president of advocacy for the American Association of Homes and Services for the Aging, moderated the second panel.

The Swedish Experience

GERT ALABY explains that Sweden will first see workforce immigration from the new EU countries and later from Africa and the Middle East.

An anticipated shortage of nurse assistants and home helpers is the main challenge faced by Sweden's long-term care system, explained Gert Alaby, senior administrative officer for Sweden's National Board of Health and Welfare. Based on the present volume of vocational training, there will be a deficit of 200,000 of these workers by 2015.

"The quality of long-term care in Sweden is relatively good, but it must be increased to meet future demand," Mr. Alaby said. "After 2020, there will be a huge increase in demand for services, which will put pressure on people of working age."

Sweden has a universal health care system, which is fully financed by taxes and distributed according to need, and approximately 3.5 percent of Sweden's GNP is spent on long-term care. Basic health care and social services are integrated, and 290 local authorities administer the services. Almost 20 percent of citizens over 80 receive home care, and another 18 percent live in special housing for older adults.

> "The quality of long-term care in Sweden is relatively good, but it must be increased to meet future demand."

The country's long-term care workforce numbers approximately 250,000, representing about 7 percent of the total workforce. Ten percent of long-term care workers have university degrees in health and social work, and the other 90 percent are nurse assistants and home-helpers; approximately 60 percent of these paraprofessional workers have completed vocational training.

Sweden is in relatively good shape regarding its supply of nurses, physicians and health care professionals, Mr. Alaby said. In addition, the country's welfare system is well regarded by citizens and has proven its capacity to change priorities when necessary.

Despite these strengths, Mr. Alaby feels Sweden must take steps to increase the supply of skilled manpower. He notes that there is already a lack of confidence in long-term care compared with other public services, and worries about what will happen when demographic changes spur a huge increase in demand.

Mr. Alaby believes the biggest potential for recruitment of nurse assistants and home helpers is among low-skilled laborers who want to change occupations within the country. There are also opportunities to attract immigrants from new members of the European Union in the short-

term; however, Mr. Alaby feels in the long-term Sweden may need to look to African or Middle Eastern countries. Swedish older adults who are embarking on a second career represent another small pool of potential workers.

In 2006 the government will put before parliament a 10-year action plan for long-term care. The plan will discuss basic skill requirements for nurse assistants and home care personnel, and also consider a system of recognition and registration to increase the status of the occupation. There are also ongoing projects to improve on-the-job training and supervision for these workers and to provide support for their next of kin.

Mr. Alaby believes that, ultimately, employment and working conditions must be improved in order to recruit and sustain a stable long-term care workforce. Changes are needed to make it possible for people to work full time, find opportunities for advancement, and maintain their health until retirement.

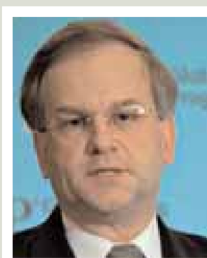
"We have the resources and opportunities to cope with the coming demographic transition, but a lot of work needs to be done to make the most of these opportunities."

Immigrants are currently underrepresented among nurse assistants and home helpers, and Sweden has a vested interest in diversifying its workforce. In the near future, a growing proportion of Sweden's older adults will be foreign-born citizens, prompting increased demand for cultural sensitivity and foreign language skills among personnel.

While demand for foreign-born workers may increase, Sweden is determined to avoid having a low-skilled, low-paid market for irregular eldercare workers, Mr. Alaby emphasized. "We have the resources and opportunities to cope with the coming demographic transition, but a lot of work needs to be done to make the most of these opportunities."

Attracting International Health Professionals

International recruitment can be an ethical, long-term solution for employers that are facing nurse shortages, ventured Ron Hoppe, co-founder of WorldWide HealthStaff Associates. He emphasized, however, that a successful recruitment campaign requires diverse expertise in areas such as foreign licensure, immigration regulations, and social and cultural nuances.



RON HOPPE shares the steps employers must take before integrating international workers into native settings.

It is essential that employers anticipate challenges and plan for how to integrate foreign workers into their workforce, Mr. Hoppe cautioned. One of the most basic issues is that many international workers come from countries that emphasize family caregiving, so they have difficulty understanding an institutional model of long-term care. It is important for employers to help these workers gain insight into formal long-term care systems.

"The expectations of coworkers and patients play an integral role in determining the success or failure of international recruitment activity," Mr. Hoppe said. Overworked nurses in the United States often assume the arriving international workers will be fully functional by day one, and these unrealistic expectations can give rise to tension.

In order to be successful, employers must recognize that there are additional supports required to ensure immigrant workers thrive. Companies need to be prepared to help international workers, at least in the short term, with housing, transportation and social integration.

"Employers have a duty to protect the interests of migrant workers throughout the recruitment process," Mr. Hoppe said. Over the past five years, a boom in the international recruitment industry has corresponded with a rising number of fraud and abuse complaints. He urged employers to ensure any third parties they deal with are reputable and use ethical practices.

"Employers must realize that immigrant workers are not a source of inexpensive labor," Mr. Hoppe cautioned. He emphasized that companies should recognize the credentials of international workers and give appropriate credit for their years of experience.

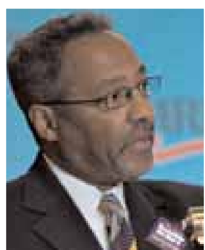
Regarding the issue of "brain drain," Mr. Hoppe argued that there are countries that have an excess supply of capable, professional caregivers. He believes international recruitment is ethical if the source country has a sufficient supply to replace departing workers and if it benefits from remittance payments and the transfer of knowledge.

Mr. Hoppe asserted that international recruitment is a practical and inevitable response to staffing shortages. Long-term care and health care employers have traditionally been forced to resort to short-term fixes, such as the use of temporary agencies or incentives to work overtime. Yet, these quick fixes are not sustainable, leading many employers to seek out a more permanent solution.

"Employers have a duty to protect the interests of migrant workers"

Looking ahead, Mr. Hoppe expects to see employers and educational programs establishing training sites in foreign countries. There are already American schools of nursing in China, and plans are in the works for Thailand as well. Mr. Hoppe views these satellite schools, which will be taught in English by American instructors, as the next evolutionary step in international recruitment.

Working Hand in Hand



HOWARD CROFT talks of the support the Service Employees International Union is giving to domestic and foreign born caregivers.

"How do we provide quality care in an industry characterized by low wages and benefits and high turnover?" challenged Howard Croft, deputy director of the Service Employees International Union's long-term care division. He believes the answer is to give workers—both native and foreign born—a voice on the job and a framework to improve their working conditions.

The Service Employees International Union (SEIU) began working with nursing home aides in 1964. It

currently represents 515,000 long-term care workers, making it the largest organizer of direct care workers in the world. SEIU also represents more immigrants than any other union in the United States.

Mr. Croft noted that the direct care workforce in the United States has some marked differences when compared with the larger workforce of the country. Approximately 91 percent of nursing home aides are women, and less than half of the country's home health aides are white.

"When we talk about direct care workers, we're talking about an overwhelmingly female workforce," Mr. Croft said. "In contrast to the overall American workforce, it's a 'browner, blacker' workforce, and it's a workforce made up of single parents."

"When we talk about direct care workers, we're talking about an overwhelmingly female workforce … In contrast to the overall American workforce, it's a 'browner, blacker' workforce, and it's a workforce made up of single parents."

Issues relating to diversity in the workplace are an inherent concern for SEIU, Mr. Croft explained. Approximately 40 percent of its members are people of color, and 56 percent are women. He noted that over half of SEIU members belong to locals that are led by women or people of color.

Mr. Croft highlighted two SEIU successes stories in the state of California, where many long-term care workers are foreign born. In the state's Local 434B, for example, 60 percent of union members are immigrants.

A major victory for the SEIU dealt with California's In-Home Support Services (IHSS) program, which is the Medicaid-funded program that provides personal care to people with disabilities. SEIU joined with consumer advocacy groups to get the state of California legislature to pass a law requiring each county to create an employer for home care workers.

Prior to the formation of these public authorities, IHSS workers only earned minimum wage and lacked access to benefits. With collective bargaining, wages in California have increased from US$6.75 an hour to an average of US$8.10, and 17 percent of workers are now covered by IHSS health benefits.

These changes were beneficial for the system as well, emphasized Mr. Croft. The annual workforce turnover rate fell by 30 percent, and there was a 54 percent increase in the number of Medicaid-funded personal care workers. The number of consumers using IHSS rose 47 percent.

SEIU locals also worked to create training centers for home care workers. These centers offer citizenship classes, English courses, career skills development, and health care training in a variety of languages.

Personal care workers need a strong advocacy system and institutional framework to improve working conditions, Mr. Croft reiterated. "The starting point for a good job is decent wages and benefits, and large numbers of direct care workers do not themselves have access to health care."

The problem, Mr. Croft asserted, is that long-term care isn't part of the conscious United States political agenda. SEIU polling reveals that most American consumers support higher long-term care spending, but only when probed. "We can't make gains unless the consumer stands with us," he said.

Discussion

Questions were raised as to whether it was feasible to develop a professional society of international recruiters to promote ethical conduct. Mr. Hoppe responded that he did not believe any such organization was in the works. He added that, as the international recruitment industry has evolved, employers have become more savvy at sorting out which recruiters are credible.

There also was discussion, based on personal experience, about how the quality of long-term care in Sweden seems to differ based on a person's location. Mr. Alaby replied that the system is decentralized, and the responsibility for providing services falls with the local authorities. He acknowledged that discrepancies in service is a concern and said the differences are being evaluated and reported to the government.

MEMBERS OF THE SECOND PANEL DISCUSS NEW WAYS TO FINANCE AND PROMOTE FOREIGN-BORN CAREGIVERS.

PANEL III

THE CHANGING DELIVERY OF LONG-TERM CARE

Suzanne Weiss, senior vice president of advocacy for the American Association of Homes and Services for the Aging, moderated the final panel.

Germany: Social Insurance for the Future

HANS-JOACHIM VON KONDRATOWITZ discusses the changes in attitudes of Germans to immigrants as caregivers.

In 1994 Germany enacted a mandatory social insurance model for long-term care spurring new competition in the field and the development of formal caregiving infrastructure, explained Hans-Joachim von Kondratowitz, Ph.D., a professor at the German Centre of Gerontology. As of 2003, more than 2 million people were receiving cash payments or in-kind services to provide for care in the home or in an institutional setting.

Dr. von Kondratowitz noted that over 1.4 million people chose to receive care at home. Approximately two-thirds of that group was cared for exclusively by family members, with the other third receiving formal services. He commented that, while most Germans still prefer cash payments, there is growing demand for in-kind services.

There are over 10,500 home care services in Germany, and the field is split fairly evenly between private organizations and welfare associations. The majority of these providers serve up to 70 older adults, rendering different benefits in-kind such as housekeeping services and domestic health care.

Germany's formal home care workforce predominately consists of part-time female workers. Nurses are the dominant professional group, followed by "Altenpfleger," who provide social care specifically for older adults.

> "For the first time, immigration is being discussed under a positive connotation, as enriching society with specific knowledge which would not be available otherwise."

Nursing homes, in contrast, have a fairly equal distribution of full-time and part-time workers. Altenpfleger are the main professional group, followed by nurses.

Germany's 2004 Care Thermometer, based on an annual survey of health care employees, revealed a trend toward concentration in the market and fewer open positions. The survey also found that, although East Germany has a more modern infrastructure for eldercare, West Germany has been more successful in recruiting personnel to the field. In general, though, Germany is experiencing an increase in qualified applicants.

With respect to the use of international workers, the country has traditionally taken a negative view of immigration, but the tide is beginning to turn. "For the first time, immigration is being discussed under a positive connotation, as enriching soci-

ety with specific knowledge which would not be available otherwise," Dr. von Kondratowitz said. Still, concerns exist about whether foreign-born workers will undermine national care standards.

Irregular workers already play a role in Germany's caregiving labor market, Dr. von Kondratowitz noted. Estimates show that there are 100,000 eastern European caregivers, mostly Polish, working illegally on a full-time basis in private households.

Before Poland entered the European Union, these workers came into Germany using a tourist visa and could only stay for three months. However, since these workers can now enter Germany as European Union citizens, the new situation may cause changes in black market recruiting and networking.

Dr. von Kondratowitz emphasized that there is widespread opposition in Germany against "shadow work" arrangements. Unions and provider groups complain that irregular workers create an uneven playing field. The government opposes black market activity, because it fails to contribute to Germany's social insurance system.

Despite these drawbacks, Dr. von Kondratowitz acknowledged that high costs of care make arrangements with irregular workers highly attractive for families. He also questioned whether the Polish workers brought certain intangible qualities to their work that made them more desirable caregivers. He believes the strong demand for these workers represents a weak spot in the way Germany delivers services and warrants further exploration.

MAJD ALWAN explains how technology can play a role in streamlining the work of long-term caregivers.

Technology as a Tool

It will take a multifaceted approach to meet the demands of an aging society, and technology will be an important part of the solution, said Majd Alwan, Ph.D., director of robotics and eldercare technologies at University of Virginia's Medical Automation Research Center in the United States. "Technology can provide cost effective care coordination tools to help caregivers attain higher efficiencies and deliver high-touch quality care."

Dr. Alwan highlighted the concept of "passive monitoring," which involves embedding sensors in an older adult's natural environment. For example, University of Virginia's Medical Automation Research Center has developed a passive vital-signs system that can be built into a bed or chair. The system measures and reports a person's pulse, breathing, and restlessness, and can alert caregivers if these vital signs exceed or drop below a pre-determined level.

Other passive monitoring experiments are using motion and temperature sensors to infer activities of daily living. The idea is to collect data continuously and unobtrusively, and then transfer the data to a remote server so it can be stored and analyzed.

At the most basic level, passive monitoring can be used to give feedback to older adults about their personal health. To be most effective, however, Dr. Alwan believes a care provider must be part of the loop. In such a model, the technology would provide an objective, continuous assessment of residents, and the care provider could then arrange appropriate services to meet their needs.

Technology also can enable better information sharing, Dr. Alwan noted. If the data from passive monitoring is integrated into an electronic health record, a physician could prescribe interventions and immediately gauge their effectiveness.

> "In the global village, ideas cross borders faster than people."

While technology holds promise for the future, there are challenges to overcome. For new technologies to be successful, they must gain acceptance with both older adults and their caregivers. There also are issues surrounding payment and liability. From the standpoint of workers, new technology could mean more training and certification requirements.

To address these issues, Dr. Alwan's center is working to prove that technology is a sound investment. In one pilot study, passive-monitoring systems in an assisted living facility enabled early detection of health issues. The resulting interventions saved the payer over US$50,000 in three months. The monitoring systems also increased caregivers' efficiency and reduced their workload.

In the future, countries may not only be importing caregivers, but caregiving technology as well, Dr. Alwan suggested. Japan and Korea have made huge investments in technological development, and advances are occurring rapidly in areas ranging from personal care robots to bathing machines.

Technology holds the potential to increase quality of care, automate assessment and documentation, and reduce paperwork, closed Dr. Alwan. "In the global village, ideas cross borders faster than people."

Forecasting the Future

DEBRA LIBSON proclaims, "The only way to predict the future is to invent it."

"The best way to predict the future is to invent it," Debra Lipson quoted, laying out several possible scenarios for how long-term care might evolve. Ms. Lipson, a senior health researcher with Mathematicia Policy Research, emphasized that there are many big unknowns with respect to the factors that influence the demand and supply of the caregiving labor force.

While aging populations are expected to create higher demand for long-term care services, no one can be certain whether disability levels among older adults will stay the same or diminish, Ms. Lipson noted. She added that, although fewer family members are available to provide informal care, it is unknown what proportion of family caregivers would be willing to forego other employment options if their caregiving time were compensated.

Ms. Lipson questioned whether public financing would increase enough to avoid dependence on unregulated workers in home care settings. She also discussed what impact technological advances might have on the ability of older adults to care for themselves after surgeries or hospitalizations.

On the workforce supply side, general labor shortages are expected to occur as a result of rising dependency ratios. While this development could exacerbate the shortage of long-term care workers, reforms in retirement and labor policies might lead to higher labor force participation among older workers.

The very notion of shortages remains subjective, Ms. Lipson emphasized, calling for the development of methods to standardize data across countries. She suggested it is difficult to gauge the true nature of the shortage because long-term care employers have such high turnover rates.

"Solving the long-term care workforce challenge of the future means recognizing and ultimately embracing our interdependence in a global marketplace and a globalized world."

Ms. Lipson noted that immigration laws and international trade agreements will impact the cross-border mobility of labor. She called for the negotiation of bilateral agreements, rather than global ones, to tailor the number of workers, training requirements and transition supports to the needs of each source and destination country.

The overriding policy question is whether governments and provider organizations in developed countries are willing to invest the necessary resources to provide high quality care, Ms. Lipson challenged. Will they make paid caregiving a viable and respected career choice for their own citizens, or will job conditions remain low and deteriorate further?

Ms. Lipson questioned whether international recruitment should be viewed as a stop-gap measure or a long-term solution. "If we continue to rely on a largely untrained, poorly paid immigrant labor force, we will perpetuate a vicious cycle of poorly trained workers, leading to poor quality of care and a poor image of the long-term care field," she said. "On the other hand, reliance on an immigrant labor force could be a boost to the long-term care system, if their needs for language, cultural and clinical skills training were met, and as a result, the field was strengthened and care improved."

The workforce challenges facing long-term care seem daunting, Ms. Lipson acknowledged, but there may be some unexpected solutions. For example, rather than importing workers, some have suggested that the flow should be reversed by encouraging older people to move to developing countries where workers are plentiful and care is less expensive.

Ms. Lipson closed by emphasizing that the challenge of creating jobs for young people in the developing world is related to how developed countries ensure the social, health and economic security of their aging populations. "Solving the long-term care workforce challenge of the future means recognizing and ultimately embracing our interdependence in a global marketplace and a globalized world."

Discussion

The issue was raised as to whether personal care robots were being well received by older adults in Japan and Korea. Dr. Alwan responded that preliminary research shows this technology is being perceived positively, adding that the market for it is estimated at one trillion Japanese yen. Over the next 25 years, some experts predict that market could grow to 50 trillion yen.

Other questions were asked about if these new technologies would ever truly be affordable. Dr. Alwan reiterated that payment policy is a key issue, emphasizing that the solution lies in demonstrating the return on investment to payers.

There was separate discussion surrounding the changing long-term care market in Germany. Dr. von Kondratowitz explained that criticism of the public sector's dominance in the 1960s fueled growth of the private sector. He added that one outcome of the Long-Term Care Insurance Law has been increased competition in the marketplace.

MEMBERS OF THE THIRD PANEL DISCUS HOW FOREIGN-BORN CAREGIVERS AND TECHNOLOGY COULD SHAPE THE FUTURE OF LONG-TERM CARE DELIVERY.

LOOKING AHEAD

JOHN ROTHER OFFERS INSIGHTS INTO THE MATERIAL DISCUSSED AT THE CONFERENCE IN HIS CLOSING REMARKS.

LOOKING AHEAD

AARP Executive Officer of Policy and Strategy John Rother closed the forum by thanking panelists and audience members for their insight. He stressed that the international migration of workers is an important component of the long-term care workforce puzzle, but that it is not the answer alone. Countries also must focus on cultivating a domestic labor force and making improvements through system design and technology.

More research is needed to gauge the impact foreign-born workers have on quality of care, Mr. Rother noted. In some cases, these workers enrich older adults' experiences, but there also can be challenges around communication and cultural differences. Mr. Rother pledged that AARP would continue to press for a long-term care system that is responsive to the needs of older adults, and that fostering an international dialogue on workforce development remains a key part of that goal.

CONCLUSIONS AND EMERGING ISSUES

Over the next few decades, virtually every country will be challenged with how best to meet the growing needs of citizens who can no longer care for themselves. The long-term care workforce is already transnational, and that phenomenon will continue to grow, requiring greater coordination between countries.

With respect to international recruitment, there is a clear need for increased monitoring and enforcement of international standards and codes of ethics. Yet the most essential question for countries will be how to elevate the profession of long-term care by improving wages, benefits and training opportunities, and addressing the negative stigma surrounding long-term care work. The prevailing issue is not one of migrant workers versus domestic workers, but of how best to equip all workers to deliver quality care.

In conjunction with the conference, the AARP Public Policy Institute released a new report that examines trends and patterns of international migration in long-term care workforces. The report and other conference materials are available at www.aarp.org/ltcforum.

This "independent aging agenda event" was designed to provide input to the Policy Committee of the 2005 United States White House Conference on Aging. This event is neither sponsored nor endorsed by the White House, nor does it in any way represent the policies, positions, or opinions of the 2005 White House Conference on Aging or the federal government.

CONFERENCE PARTICIPANTS LISTEN TO A DISCUSSION ON THE FUTURE OF LONG-TERM CARE SERVICE DELIVERY.

REPORT CREDITS

Proceedings reported by Michele Hayunga

601 E STREET NW
WASHINGTON, DC 20049

www.aarp.org/globalaging