"Migrants are often vilified in the countries where they live and work, yet by plan or by chance, they are vital to resolving the challenges of the aging that many countries are undergoing."

An Aging World Relies on Migrant Care Workers

CATI COE

A slow-moving but powerful demographic transition is happening around the world. As a result of declining fertility and greater access to clean drinking water and antibiotics, the world population is growing increasingly older. In a world full of tragedies, the aging of the population is a tremendous success story reflecting the effects of public health measures on overall human well-being. Individuals are living longer, with opportunities to meet their grandchildren and even great-grandchildren, but often with chronic medical conditions that require ongoing treatment. As the World Health Organization stated nearly a decade ago, "For the first time in history, most people can expect to live into their sixties and beyond."

The changes go beyond the individual level. Most societies around the world are aging, with a declining proportion of children and young adults and an increasing proportion of adults older than 65. In 2020, across the world, one in 11 people (9.3 percent) was over 65. Those over 80 are projected to be the fastest growing demographic group for the next few decades. In the oldest countries in the world, Japan and Italy, the share of the population over 65 was 29.8 and 23.7 percent, respectively, in 2021. Even in Africa, the youngest continent, fertility rates are declining and the share of people over the age of 60 is growing.

In most countries in Western Europe, these changes happened imperceptibly over a longer period. In France, one of the first countries to face the effects of an aging population, it took more than a hundred years (from 1865 to 1979) for the share of the population over the age of 65 to double, from 7 to 14 percent. In the United States, that process took 71 years. In contrast, this demographic shift is expected to take just two decades in countries such as China, South Korea, Brazil, Tunisia, and Vietnam, where it is now under way. Some countries will have to adapt rapidly to reorient their policies and programs around an older society.

In general, however, whether they have had time to adapt or will need to respond quickly, countries are not preparing well for population aging. States with social welfare programs to support older adults rely on specific demographic formulas. Contributory pension schemes like Social Security in the United States depend on a certain ratio of contributions from those currently working to fund payments to current recipients, the largest share of whom are those who qualify by virtue of their age.

Panic that the Social Security trust fund is running out of money erupts occasionally. One such crisis in the early 2000s was averted (or projected to hit later, in the 2030s) mainly because contributions to Social Security by unauthorized migrants resulted in an unanticipated increase in the fund. Migrants with false employment documentation contribute to Social Security through employer deductions, but they will never receive disbursements due to their immigration status.

Demographic aging will force actuarial calculations to be recalibrated. That can cause social and political struggles, as with protests in France in 2023 over pension reforms raising the retirement age and increasing the years of contributory payments. People believe they are entitled to pensions, which are considered to be a result of

CATI COE *is a research chair in migration and care and a professor of political science at Carleton University.*

many years of work and are treated as long-deferred wages. Many have made decisions about their life courses based on the timing and amount of those future payments.

In countries without social welfare systems, states and individuals rely on family members to provide social support to older adults. But existing cross-generational expectations and obligations may no longer be sufficient to meet the needs of an older population. Aging societies will also need to adapt their health care systems. Migrant health care workers are being used as the solution to the dilemmas faced by aging societies. However, this raises another set of problems.

UNPREPARED FOR ELDER CARE

Health care systems have not anticipated population aging. The medical needs of an older population are more complex because seniors are more likely to have chronic conditions and comorbidities, requiring management of multiple diseases and symptoms as well as vigilance against potentially harmful interactions between drugs. In some countries where older adults with complex health care needs constitute a large share of the patients in hospitals and clinics, many of the services provided are gerontological, requiring not just medical care but also attention to social support within the household and the wider community. This trend is putting enormous strain on some health care systems.

The challenges posed by demographic aging require new ideas.

Yet the training of medical professionals has not changed in response to aging populations. Not enough people are being trained, resulting in shortages of health care workers at a time when greater numbers are needed. The Bureau of Labor Statistics in the United States projects that nurse practitioner will be the fastest-growing of all occupations between 2021 and 2031; many other health care professions make the list of the top twenty. The second-largest occupation in the United States as of May 2022 was home health and personal care aide, with 3.5 million workers, close behind the 3.6 million employed in retail sales.

Nor are enough health care professionals being trained in gerontology, particularly in developing countries. Many African medical institutions were spurred by the Millennium Development Goals and donor funding to become almost completely oriented around maternal and infant health. They are unprepared for chronic illnesses associated with aging, like heart disease, high blood pressure, and diabetes. Only now are gerontological programs starting to be developed.

Beyond medical care, older adults may have complex everyday needs, requiring help with eating, toileting, bathing, dressing, and performing household activities. In the United States, for instance, about one-third of people 65 or older report functional limitations of some kind, a share that rises to two-thirds among those 85 and older. Women are even more likely to need long-term care than men because they tend to live longer, increasing the chances of having more years in poor health. Yet most care for older adults in the West is provided by family members, peers, and neighbors. (In Europe, about 80 percent of such care work is estimated to be unpaid.)

Most of those unpaid caregivers are women. Globally, women spend on average over 250 minutes per day on unpaid care work, triple the time spent by men, and elder care is only one aspect of this labor. The historical increase in women's employment outside the home in the West has created a double or triple work shift for many: employment is combined with domestic duties and emotional labor to keep households and societies functioning.

Elder caregivers are subject to burnout since the need for care can be long-term. Particularly when the person being cared for has dementia or other chronic conditions, the needs may be complex, requiring attention around the clock. But some older adults do not have kin available to support them.

SHIFTING THE BURDEN

Models for supporting frail older adults in the West, and for lessening the burden on any relatives, have relied on institutional residential facilities. In general, residential facilities are unattractive and unpromising solutions, with historical antecedents in homes for the poor that were stigmatizing and punitive. The weaknesses of residential facilities became particularly evident during the COVID-19 pandemic, which hit older adults harder than other population groups. Living in an institution put a person at much higher risk of catching the coronavirus, and thus of dying.

When kin caregivers were banned from residential facilities due to fear of viral transmission, the pandemic also revealed the extent to which long-term care facilities are dependent on family members, given labor shortages among paid care workers. In Canada, perhaps an extreme case, family members were estimated to provide 30 percent of the care that residents received in long-term care facilities.

Most people would prefer to receive care in their own homes, yet public funding for in-home care of older adults has been extended only reluctantly and partially. The demand for long-term care typically outstrips supply. State health care programs, including Medicare for those over the age of 65 in the United States, usually pay for acute medical care and rehabilitation, not for assistance in performing everyday activities.

The challenges posed by demographic aging require new ideas for elder care. But politicians around the world seem plagued by short-term thinking, particularly in democratic countries where they are subject to short election cycles. This temporal horizon limits their ability to respond to slow-moving crises like climate change and demographic aging. Partly because there is no systematic planning on these issues, measures have been ad hoc and fragmented.

Proposed solutions have been affected by a neoliberal worldview that became dominant in Western political circles in the 1990s, when the private sector and individuals were lauded as being more efficient and innovative than state bureaucracies. In many countries, the state's role in social welfare has been limited to providing services for the poor; markets and families play key roles for most households. Since the mid-twentieth century, states have privatized responsibility, turning from delivering care as a public good to offering reimbursements that promote private and commodified solutions, generating a care market for those who can afford such services.

Although the pandemic has helped to revive the idea of care as a public good, that change in the zeitgeist has not resulted in concrete support for older adults, kin caregivers, or paid care workers. US President Joe Biden's proposal to treat care as a crucial part of infrastructure was not included in the infrastructure spending bill ultimately passed by Congress in 2021. Driven by a concern for keeping costs down and a neoliberal faith in the power of business and the individual to make better choices than bureaucracies, governments in the West facing long-term care demands have provided only piecemeal mechanisms to deal with the chronic conditions of the elderly and frail.

Consider the following examples of different approaches—from Germany, Canada, and the United States, although I could have chosen many other countries. Despite variations, these different programs converged on the use of migrants to provide elder care, resulting in the precarity and even exploitation of migrant care workers. These solutions have generally only helped older adults in wealthier households who have the resources to purchase care services.

Migrants Fill a Void

In 1994, Germany instituted a plan for long-term care insurance, giving cash benefits to older adults to pay for extended care. Because these benefits are quite a bit lower than what older adults actually need, and because it is up to the recipients to choose how to spend the cash payments, they have of course looked for cheap options for care. That has often meant employing migrants, many from Eastern Europe. Care workers are employed directly by the care recipient, with no access to government oversight or protection, which leads to more opportunities for employers to abuse workers or skirt labor regulations, such as requirements for overtime pay.

The share of migrant workers providing elder care in Germany has increased rapidly since the mid-1990s. Many migrants, made desperate by their relative poverty, have been forced to accept work as live-in carers, jobs that are not appealing to German citizens. In general, live-in domestic workers experience far more exploitation than workers who have their own homes. They can be called for help at any time and usually have restricted leisure and rest hours. Overtime is usually not calculated, much less paid, and a worker lacking alternative housing cannot easily leave an abusive employer.

Canada, meanwhile, drew on a long history of encouraging young women to immigrate and placing them as domestic workers to help settle the country. Since the 1950s, it has instituted a series of special immigration programs for migrant care workers, allowing them to work in the country under certain conditions. Although initially put in place to help families find nannies, over time Canadian caregiver programs became increasingly popular for elder care. The conditions have varied, but migrants in these programs typically have had

to stay with their employers or remain employed as caregivers for a certain period in order to qualify for permanent residency in Canada.

Linking immigration status to employment makes migrant care workers susceptible to abuse. Both past and more recent domestic work policies in Canada have been criticized for producing labor conditions akin to modern-day slavery. For instance, under current rules, employers are given considerable discretion over salaries, hours worked, and workplace conditions. Although employers must abide by prevailing wage standards that set a minimum level for salaries, domestic workers are seldom compensated for extended and overtime work hours, drastically lowering their actual hourly compensation.

Whereas most domestic servants who emigrated from Europe in the past were granted citizenship automatically, more recently care workers, mainly from the Philippines and the Caribbean, have had greater difficulty meeting the legal requirements for permanent residency through the caregiver program. Canada in this respect is similar to Singapore, Hong Kong, and the Gulf States, where migrant care workers tend not to be granted residency rights, creating a permanent underclass. They are restricted in terms of their employers or field of employment, and thus more easily subject to employment abuse.

Migrant labor has become a defining feature of the care sector.

In the United States, immigrants represent 17 percent of the labor force and constitute an important share of the health care workforce, particularly among physicians and surgeons (26 percent) and home health aides (40 percent). This concentration of migrants in the sector has occurred even though health care workers have not been specially recruited or provided with favored immigration status, unlike in Canada. Most of them, like the overall immigrant population, follow regular immigration pathways, entering through family connections, with offers of employment, or on humanitarian grounds.

Many highly educated immigrant health care professionals, however, experience difficulty transferring their existing credentials and work experiences into similar positions abroad. They can end up working instead as nursing assistants for many years, or even for the rest of their lives, resulting in a tremendous loss of valued human capital. Downward mobility into less skilled professions is a common feature of migrants' experience. Even those whose credentials are recognized must often absorb an effective wage penalty or work in the least attractive sectors of the same field, such as in less-resourced rural hospitals or in the long-term care sector, rather than in research hospitals.

Many immigrants end up as home health aides because labor shortages and turnover allow them to readily find work in the field after taking a short training course. Only a small number of older adults in the United States are eligible for home care services through Medicare, so most receiving home care pay for it out of private savings. This makes it available only to the top 20 percent of income earners, and only in the last few years of their lives.

The large share of migrants in the long-term-care workforce in the United States is not the result of an intentional policy. Instead, it is driven by the individual migration of women and the labor needs of the commercial long-term care sector. The employment of migrants in this sector is an unintended consequence of a lack of coherent policies for both long-term care and immigration.

Despite the differences in policies across these three countries, the results are the same. Migrants, particularly women, are steered into the care sector by the lack of other viable opportunities. Being trapped in that sector leaves them in a precarious position, subject to abuse both in terms of general work conditions and in relation to individual employers.

INEQUITABLE CONSEQUENCES

These three countries are not alone in relying on migrant care workers. The United Kingdom is increasingly dependent on nurses recruited from Africa. The Philippines, Indonesia, and Vietnam export nurses as well as childcare workers to numerous wealthy countries, including Australia, Iceland, and Ireland. The Israeli Ministry of Health decided in 1995 to bring in thousands of Filipino workers through a special program so that geriatric care could be shifted from hospitals to older people's homes, projecting that it would reduce the cost by as much as half. In many liberal welfare regimes, migrant labor has become a defining feature of the care sector.

Wealthy countries' reliance on migrant care workers to fill shortages in health care in general, and in elder care in particular, raises several areas of concern. To begin with, the recruitment of care labor may lead to a net loss of much-needed care workers in the countries that send migrants. Lower-income countries often suffer much larger shortages of medical personnel than high-income countries.

For example, Ghana, a middle-income country, had 5,285 doctors in 2020, serving a population of about 32 million people—a ratio of 1.65 doctors per 10,000 people. In contrast, the United Kingdom, with a population of 67 million in 2021, had 213,357 doctors—a ratio of 31.71 doctors per 10,000 people. Yet many Ghanaian-trained doctors are currently working in the UK.

Countries in the global South often use scarce public funds to train physicians and nurses, only to see those health care professionals lured away to Western hospitals and medical institutions. The higher rates of pay and better resources they are offered abroad allow them to practice medicine as they were taught, leading to higher patient success rates and less professional depression and burnout.

But the emigration of health care professionals means that lower-income countries have more difficulty ensuring the well-being of their own populations. This trend contributes to a visceral and clear marker of global inequality: differences in life expectancy. The average in 2019 ranged from 51 years in Lesotho to 84 in Japan. Ghana's life expectancy stood at 66, compared with 81 in the UK.

Moreover, elder care provided by migrants, whether in homes or institutions, reinscribes racialized citizenship hierarchies within the country to which they have migrated. Most commercial markets in care services traffic in racial stereotyping: the supposed relative merits of one nationality over another are discussed freely, and workers from certain countries receive higher pay and better work conditions than others. In the United States, there are continuities between the racialization that occurred through slavery in the nineteenth century, the occupational segregation of African American women in domestic service in the twentieth century (linked to their political and social disenfranchisement), and the disproportionate share of migrants racialized as Black and Brown who do care work today.

Migrants often encounter a hostile public discourse about immigration, and a new racial hierarchy in which they are assigned an identity that they did not have in their home countries. As W. E. B. Du Bois observed of African Americans in Philadelphia in 1899, domestic service drew "a despised race to a despised calling." The same is true of elder care and migrants today.

Migrants can mainly find work in the often-despised calling of elder care because they are stigmatized in other ways. Problems with legal status, unrecognized credentials, perceptions of language difficulties, and stereotyping by employers trap migrants in low-paid elder care positions. Their precarity as migrants or racialized persons can then be used to more fully degrade them in their work.

In my own research, I interviewed a home health worker originally from Ghana who registered with three agencies when he moved to the Washington, D.C. area from Atlanta. He was first assigned a patient in a northern Virginia suburb. When he arrived at the house, the daughter of the patient said she was "looking for an American." As he told me, "Now, I am a citizen [of the United States], but I knew what she meant: she wasn't talking about this paper [citizenship]. I went back to the agency and said that the lady was looking for an American white."

In another example, I listened to two friends from Ghana, in the apartment where one lived in a shabbily built complex in Gaithersburg, Maryland, trading "war stories" about nursing home work. One said, "Someone called me, 'You bitch, you fat bitch. You are my slave!' This was Mrs. XYZ, a long time ago. I cried." The other turned to me, saying, "They call you black monkey."

Many of my research participants shared similar incidents. Racist insults, migrant status, and discourses of enslavement were used in conflictual situations by care recipients to express their power. Given their working conditions, care workers often feel that they have to accept this verbal humiliation.

VALUING CARE

The trend of migrants emerging as a key component of care provision for older adults in high-income countries reveals two key points. First, the nation-state system that became the dominant world order after the wreckage of two world wars and the end of official colonialism is the primary mechanism by which inequality is maintained globally. Migrants seek to undo some of that inequality by migrating to wealthier countries. Immigration

policy thus becomes one of the critical means by which state power is enacted. Migrant workers are turned into an exploitable class of workers by virtue of the precarity generated by immigration regimes.

Migrants are often vilified in the countries where they live and work, yet by plan or by chance, they are vital to resolving the challenges of the aging that many countries are undergoing. The varied processes by which migrants are trapped in the elder care sector, and with specific employers, help make paid elder care services available and cheap for the wealthiest families in these countries. The labor and energy of migrant women and men is exploited in the absence of coherent state planning for an older society.

Second, care is simply not valued enough, particularly care that is feminized and not considered medical care. The work that migrant care workers typically do is key to sustaining older adults as they age in their homes, yet it is considered unskilled and is poorly compensated as a result. Women are thought to acquire whatever skills are needed in this work naturally, through gender socialization in their households.

Yet in my research, I found that care workers needed to develop a set of strategies—for instance, to deal with a patient with dementia who might balk at the care worker ("a stranger") showing up at the door, attack the worker verbally or physically, or put themselves in danger by wandering off. Care workers mainly learned these strategies from one another in private conversations and from the accumulation of experience in doing home care work. This prepared them to help their patients' families deal with a death at home, something beyond the experience of many Americans who are used to hospitals structuring the dying process for their relatives and for whom hospices provide too little support (typically about an hour or two a day).

Policies that increase immigration are critical to relieving shortages of elder care workers. Only migrants are willing to settle for the unattractive conditions of care work, including the forms of domination they encounter in jobs in which they are treated as servants. The West has revived domestic servitude in response to its aging societies. This untenable system should be reformed to provide adequate protections for the rights of these key workers.

Long-term care must be better funded and accorded more respect. It should be beneficial to the person who provides it, as well as to the recipient of such care. Other countries now facing similar demographic transitions may come up with different solutions that support care workers as well as older adults. In any case, it is clear that we need to find more humane ways of resolving this slow-moving and relatively invisible crisis—in ways that honor older adults, their loved ones, and paid care workers alike. ■