The Role of Migrant Care Workers in Aging Societies:

Report on Research Findings in the United States

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EXECUTIVE SUMMARY

America's aging population is generating an increasing demand for their care, and foreign-born workers will supply an important part of that demand. Yet, there has been relatively little research that addresses the role that the foreign born play in the long-term care (LTC) for the elderly population. In 2007, the Institute of Medicine (IOM) charged a Committee on the *Future Health Care Workforce for Older Americans* to assess their health care needs. The IOM's report raised concerns about the adequacy of tomorrow's workforce to care for the growing population of seniors, although it did not focus on the foreign born. This report investigates migrants' role in eldercare in the United States, particularly as professional caregivers or physicians, dentists, nurses, and therapists, as well as direct care providers or home health aides and lower-skilled providers. This research was undertaken as part of a two-year, internationally collaborative project, with funding from several sources, involving Ireland, the United Kingdom, and Canada.

HEALTH AND SOCIAL CARE POLICIES IN THE UNITED STATES

Long-term care (LTC) for elderly Americans is a patchwork of public and private sector policies and programs that have evolved over time to meet the growing demand for services. In 2004, public funds, primarily Medicaid and Medicare, accounted for approximately 60 percent of national long-term care spending; out-of-pocket spending accounted for an additional one-third. Most long-term care is unpaid assistance provided by family and friends. Yet, long-term care is provided in a range of settings and there is an increase of Medicare home health and home care use. Nurses provide the majority of skilled services, but most paid providers of long-term care are the direct care workers who are

the frontline caregivers. One survey of states found two-thirds reported shortages of certified nursing assistants and 60 percent reported shortages of home health aides.

IMMIGRATION POLICY AND THE CARE SECTOR

The United States has few dedicated avenues of legal admission that select for professional care workers, and no effective avenues that target direct care workers. Both permanent and temporary classes of admission include some employment-based visas for professionals in health care, but they tend not to favor long-term care workers. Direct care workers enter predominantly through the family or refugee classes of admission and, to a lesser extent, are unauthorized workers (see below). While lobbying efforts are underway to relax the multiple requirements for admission, there is substantial disagreement on the possible impact of such a course of action. For example, the American Nursing Association (ANA) testified against legislation that would increase the number of foreign-educated nurses, questioning claims of current worker shortages.

THE FOREIGN-BORN WORKFORCE IN LONG-TERM CARE

Our analysis of census survey data found roughly 3 million workers in long-term care. Professional care workers – practitioners, nurses, and therapists – are a critical but small share of the long-term care workforce and foreign-born providers are about one-seventh of these workers. Direct care providers – home care aides and nursing and home health aides – are about 80 percent of the long-term care workforce and immigrants are about one-fifth of direct care workers. As to where immigrants come from, more Asians are found in higher-skilled professions relative to their Latin American and other counterparts. Foreign long-term care workers are concentrated, often in the central part, of two dozen cities; one-quarter reside in New York. They are better educated, work

more hours, are more likely to be employed full time, and they earn slightly more than natives.

THE SUPPLY AND RECRUITMENT OF ELDERCARE WORKERS

Our fieldwork in Phoenix, Arizona and in the Washington DC-Baltimore metropolitan area indicates that employers use a variety of strategies to hire foreign-born nurses. Available data indicate that few nurses are hired from abroad through third party recruitment agencies. Still, there has been a ten-fold increase in the number of recruitment agencies, hiring from abroad, since the late 1990s. Some of the larger health care providers interviewed for this project indicated that they recruit nurses directly from overseas for specific jobs, often directly recruiting themselves and not using third party agents. In contrast, none of the direct care workers we interviewed arrived in the United States after being recruited or with explicit job-related motivations. Some came as refugees; others came as immigrants to reunify with family members. Employers report that immigrants are highly committed to working with the elderly, and that communication or language issues are the dominant challenge.

EMPLOYERS' DEMAND FOR MIGRANT CARE WORKERS

We undertook a web survey and found that 53 percent of nursing home/assisted residential care employers and 40 percent of home care companies have hired immigrant care workers. Employers report that finding U.S.-born workers is a challenge and, thus, they turn to immigrants. The respondents' foreign-born workforce appears to be stable; most hired less than 20 percent of their current foreign-born workforce during the past year. Furthermore, two-thirds stated that immigrants are advantageous because they are committed to caring for elder clients and tend to be very respectful. Poor English skills were the biggest challenge. Few employers indicated that foreign-born workers were willing to accept lower wages than their native counterparts; more than

55 percent indicated the opposite. More than one-third stated that the immigration regulations governing the employment of foreign-born nurses present serious challenges to the hiring process.

CONCLUSION AND POLICY IMPLICATIONS

The pathways to employment that direct and professional care workers take are not likely to change. Future immigration reform may ease admission for entire classes of immigrants, but until then it is difficult to make a case for singling out visas to target long-term care providers. In the first place, they are no more likely to be in shortage than some other occupations. Additionally, for professional care the better long-term solution would be to increase the capacity of domestic training institutions which, being understaffed and underfunded, are turning applicants away. If changes to the admission system are not a first-order policy imperative, our research finds several important steps that should be taken to improve the labor market for foreign-born LTC workers. First, we strongly encourage the adoption of voluntary codes of conduct by recruiters, as well as ongoing review and evaluation of the industry. Second, proactive employers will undertake the necessary training, but we encourage government support for training in communication and worksite skills either through direct funding or tax breaks to community colleges or businesses. Thirdly, research and sensitivity training should seek to reduce workplace conflicts between foreign- and native-born providers, as well as address concerns of elderly clients. Fourthly, we support the Institute of Medicine's calls to improve the professionalization of the direct care workforce through extending and enhancing certification requirements.

INTRODUCTION

America's aging population is generating an increasing demand for their care and foreign-born workers will supply an important part of that demand. Yet, there has been relatively little research that addresses the role that the foreign born play in the long-term care (LTC) for the elderly population. In 2007, the Institute of Medicine (IOM) charged a Committee on the Future Health Care Workforce for Older Americans to assess the health care needs of elderly Americans. The committee reviewed the education and training, models of care, and public and private programs for workers engaged in caring for America's aging population. The IOM's report raised concerns about the adequacy of tomorrow's workforce to care for the growing population of seniors, although it did not focus on the foreign born.[1] In order to better understand tomorrow's workforce challenges, this report investigates migrants' role in eldercare.

New trends are emerging in the American market for LTC of the elderly. There has been a movement away from hospitals and institutionalized care facilities to the direct provision of private services and LTC in homes. Roughly two-thirds of the elderly live with others in a household, not quite three-tenths live by themselves, and the remainder lives in group quarters.[2] This has led to a tripling of the workforce in non-institutional settings while the workforce in institutional care has remained relatively stable. The supply of *professional care* workers – physicians, dentists, nurses, and therapists – has grown but moderately. We have seen a more robust growth in the workforce of *direct care* providers – home health aides and lower-skilled providers – in the LTC industry. And as we shall see, immigrants are an important part of the entire LTC workforce. Our interest is to better understand the role that they play in caring for the elderly.

We consider both professional and direct care providers, although much of our interest focuses on the direct care providers where the role of immigrants has been least studied. Direct care workers are the front-line workers in caring for aging Americans. Their job tasks include duties such as bathing, dressing,

toileting, and assisting the elderly with the "activities of daily living" (ADLs). The Bureau of Labor Statistics predicts that these occupations will be the second- and third-fastest growing occupations in the United States between 2006 and 2016.[3] Workers in these positions fulfill direct service-oriented tasks and have the most contact with the elderly. To date we know very little, however, about the demographic characteristics and attributes of these workers relative to other occupations in the LTC industry. We know very little, indeed, about the foreign born who are caring for the elderly in the United States.

Long-term care for elderly Americans is a patchwork of public and private sector policies and programs that have evolved over time. As is often the case in America, there is no comprehensive national policy, and there are significant differences across states. Long-term care includes a variety of services and supports provided by unpaid (informal) and paid (both formal and informal) providers, concentrating on helping individuals to function as well as possible in the face of disability. It encompasses a range of help with daily activities, over a long period of time, for chronically disabled people. It frequently involves family members, particularly wives and adult daughters, as providers and decision makers. Paid caregivers are an important respite for the family caregiver. Services include assistance with such activities as dressing, bathing, toileting, transferring, and eating. Often people who need LTC also require primary and acute care when they are sick. The provision of this care in the United States is complex with a division of federal and state responsibilities, and funding that both supplement or provide the sole source of care for the elderly. Individual funds and the private sector play a key role.

This report draws upon research undertaken over a nearly two-year period. It draws upon a review of available information and new, exploratory research. The research is part of an international collaborative research project, involving Ireland, the United Kingdom, and Canada. These countries are of particular interest given that the migration of care workers between the four sites has been considerable in the past, and each nation is now thought to be a significant participant in the global migration of care workers. The four countries also

represent an interesting blend of established and recent immigration. Research partners include the Community Health Research Unit (University of Ottawa), the Irish Centre for Social Gerontology (National University of Ireland Galway), and the Centre on Migration, Policy and Society (University of Oxford), which has been the international project coordinator. This collaborative effort was funded from many sources including the Atlantic Philanthropies, the Nuffield Foundation, the John D. and Catherine T. MacArthur Foundation, the Alfred P. Sloan Foundation, the German Marshall Fund and the Rockefeller Foundation (see appendix 1).

This report on the United States uses the same methods employed in our partner countries. A background paper on the context of care was written by Drs. Stone and Sanders of the American Association for Homes and Services for the Aging. All other original research was gathered primarily in one of three ways: fieldwork (individual interviews, focus groups, and participant observation) with foreign care providers and their employers as well as representatives of professional associations of foreign-born caregivers, employer responses to an online survey, and analysis of U.S. census surveys. We provide additional discussion about the methods in relevant sections in what follows, but note here that the interviews with migrant providers and their employers were undertaken primarily in Arizona and the Washington, DC-Baltimore metropolitan area. These are interesting areas to explore because both have a significant presence of migrant workers and yet they differ insofar as Arizona has long been a leading place of elderly retirement, while the Washington-Baltimore metropolitan area is a more recent site both of retirement and immigration.[4] The online survey benefited from the cooperation of major health provider associations and resulted in a large, non-random sample that round out our fieldwork findings. The census surveys are, in turn, random samples with variables that permit us to indentify workers in the long-term care industries. Finally, the research benefited from periodic meetings of the international team, the feedback to the international project of an advisory council of experts, and a roundtable held in spring 2008 at the Rockefeller Foundation Bellagio Center.

In the report, we first discuss the provision of health and social care in the United States which is structured by its financing, the settings where care is delivered, and the workforce that provides care. Next, we discuss the admission system and the various ways in which immigrants come into the United States, as well as the regulations that govern immigration and the accreditation required of professional care providers. A third section of the report draws on census samples to describe both the direct and professional care workforces in LTC industries, focusing on the countries that supply immigrant workers, their demographic characteristics and employment conditions. The fourth section of the report turns to a detailed discussion of our findings from fieldwork with workers and employers in Arizona and the Washington-Baltimore metropolitan area. It describes the processes by which immigrants find their way into LTC employment and the evolving role of recruitment agencies. The fifth section reports the results of a large-scale, online survey of LTC employers and their difficulties in recruiting U.S.-born workers and, in turn, their use of foreign-born workers. It focuses particularly on both the advantages and challenges posed by direct and professional care immigrant labor. Finally, the conclusions summarize the research and present some policy recommendations for the admission and employment of immigrants in LTC occupations.

HEALTH AND SOCIAL CARE POLICIES IN THE UNITED STATES

Long-term care is bound up in three domains or a "triple knot" of its financing, setting, and workforce.[5] Major public funds come from the Medicare program for the elderly, as well as the Medicaid program which pays for services in nursing homes and for poor individuals. But there is wide variation in the dollars each state matches to the federal payment, as well as the implementation of the program. Further, one-third of all expenditures are borne by elderly consumers and their families. More and more acute care services formerly provided in hospitals are being provided in skilled nursing facilities and private homes are increasingly the setting of first recourse. And while a workforce of

both professional and direct care providers plays a significant role, most services are provided by unpaid family members and friends.

Sources of financing

Care services are financed by a patchwork of funds from the federal, state, and local levels, as well as by private dollars, primarily paid from the consumer's own pocket. In 2004, national spending on older adults totaled about $135 billion, or roughly $15,000 per disabled elderly person.[6] National, public funds accounted for approximately 60 percent of LTC spending on the elderly. Out-of-pocket spending accounted for another one-third, private long-term care insurance for four percent, and various other federal, state, and local agencies for most of the rest.[7]

The majority of public spending is for nursing home care, although the proportion spent on home and community-based alternatives has increased substantially – from 21 percent in 1990 to 34 percent in 2002.[8] Long-term care can be costly. In 2007, the average annual cost of nursing home care was $68,985 for a semi-private room and $77,745 for a private room.[9] The national average annual cost for assisted living was $35,628, while care purchased outside of an institution typically is less.[10] Nurses hired through an agency charge between $20 and $40 per hour. The services of a personal care attendant or home care aide might cost $12 to $18 per hour through an agency or about half that amount in the "underground" market.

The Medicaid program, a federal/state safety-net health insurance program created in 1965 to finance care for the poor, has become the major public payer for long-term care. It accounted for 35 percent of all LTC spending on the elderly in 2004 and 40 percent of spending for nursing home care.[11] In 2005, nursing home care accounted for 63 percent of total Medicaid spending on long-term care.[12] Although the federal government establishes overall rules and standards for the program, there is wide variation in the amount each state makes available to match the federal payment and how the programs are implemented.[13]

Since 1970, states have been required to cover home health services for those who are eligible for Medicaid-covered nursing home care and states have had the option to offer personal care services under their state plans.[14] In 1981, Congress authorized the waiver of certain federal requirements to enable a state to provide home and community services. By 2005, 37 percent of Medicaid LTC expenditures covered home health, personal care, and home and community-based services.[15] During the period from 1992 to 2005, expenditures for these services grew at a rate of 15 percent per year, more than double the rate of growth for the overall Medicaid long-term care expenditures.[16] However, Medicaid policies remain biased in favor of nursing home care.[17]

Medicare. The federal Medicare program provides health insurance to almost all people age 65 or older. It financed 20 percent of national long-term care expenditures in 2005, including 16 percent of nursing home care and 27 percent of home health care.[18] Although Medicare was legislated primarily to pay for acute and primary care, the program does provide limited coverage of skilled nursing facility and home health care services to Medicare enrollees who meet certain requirements. In the case of home health care, Medicare will pay for skilled nursing, therapy, and aide services for individuals who are not able to leave their homes because of their health condition and require intermittent care.

Private Insurance. A long-term care insurance market has existed since the 1960s, but it is only since the mid-1980s that national insurance companies began marketing nationwide. About 1.2 million policies were in force in 1990, compared with 7 million in 2005. Still, private long-term care insurance financed only about four percent of the elderly population's long-term care in 2004. In that year, 29 percent of long-term care insurance policies in force were held through employer-based programs.[19] Although they offer significant advantages over individual policies, in most employer plans the policy holder pays the entire premium. And it is estimated that only 6 to 9 percent of eligible employees take advantage of the employer-based plans.

Settings of long-term care

Long-term care is provided in a range of settings, depending on the recipient's needs and preferences, the availability of informal support, and the source of reimbursement. Much gerontological literature refers to a continuum of care, identifying the nursing home as the most restrictive setting and one's own home as the least restrictive. However, if an individual is homebound and is not getting the services that would facilitate some independence, one's own home can be as restrictive as a nursing home.

Nursing Home. The nursing home or nursing facility is the primary institutional setting for long-term care. In 2004 there were approximately 16,100 nursing homes with 1.73 million nursing beds.[20] Proprietary homes accounted for 62 percent of all facilities; 31 percent were non-profit and the remainder were government-sponsored. Approximately 88 percent of the facilities were both Medicare and Medicaid certified.

Residential Care. "Home and community-based care" is a catch-all phrase that refers to a wide variety of non-institutional settings, ranging from various types of congregate living arrangements to the homes of care recipients. Residential care tends to be regarded as an option for individuals who may not need nursing home assistance but who can no longer remain in their own homes. The boundaries between nursing homes and residential care are far from clear. Many assisted living and board and care facilities are large buildings that strongly resemble hotels or nursing homes in physical appearance and philosophy. Other residential care options are small, homey settings that offer privacy and choice to residents.[21]

Residential care is handled by state and local jurisdictions, while nursing homes are licensed and regulated by the federal government because they receive significant Medicare and Medicaid reimbursement. Consequently, there is no consensus on the definition of "residential care" and their nature and scope of services vary tremendously.[22] Board and care homes are licensed and

regulated under more than 25 different names; many more are unlicensed. Most homes provided three meals a day and supervision of medication.

Adult foster homes are small-group residential settings typically housing between three and six individuals.[23] This setting closely resembles a private home in the community. In a typical model, the owner of the home or someone hired by the owner lives there and provides the services that residents need. Most adult foster homes will be unable to care for Medicaid eligible or other low-income clientele with heavy levels of disability. This setting has only recently emerged as a setting for middle-class elderly individuals.

Although no single definition of assisted living exists, the term tends to describe a residential setting that is similar to board and care but that also arranges personal care and routine nursing services.[24] When the concept was first operationalized two decades ago, assisted living was envisioned as a setting that combined much of the high level of care provided in a nursing home with desirable features of apartment life. In practice, many self-described assisted living facilities have neither the service capability nor privacy and home-like accommodations.

There are also more than 1.8 million elderly people, the majority of whom are now 80 years or older, living in subsidized rental housing. Yet, a federal commission projected that 730,000 additional subsidized rental units would be required by 2020 just to accommodate the same proportion of elderly residents as they do today.[25] The U.S. Department of Housing and Urban Development has taken important steps to assist states in making use of existing housing stock by providing grants to physically convert subsidized housing properties.[26]

Adult Day Care. The number of adult day service providers has almost doubled from 2,000 in 1985 to 3,500 in 2002.[27] Twenty-one percent of adult day centers are based on the medical model of care, 37 percent are based on the social model with no health-related services, and 42 percent are a combination of the two. More than three-quarters of the centers are not-for-profit, serving an

average of 25 individuals at a cost of $56 per day. The majority of these programs are open only Monday through Friday for eight hours.

Home Care. Most elderly people who need long-term care live at home, either in their own homes, with or without a spouse, or in the home of a close relative such as a daughter. In this setting, a range of home health care and home care services, paid and unpaid, may be provided. Home care can include skilled nursing and assistance with personal care (i.e., home *health* care), but home care also tends to be non-medical delivering primarily personal care. In 2007, there were 9,284 Medicare-certified home health agencies.[28]

Providers of care

Much long-term care, in contrast to more medically oriented services, is unpaid assistance provided by family and friends. This has been true in the past, and despite the persistent myth of family abandonment fostered by many policy makers, it remains true today. Frontline caregivers, sometimes referred to as paraprofessional workers, dominate the much smaller group of paid providers.

Informal Care. Nearly all, about 95 percent, of non-institutionalized elders with long-term care needs receive at least some assistance from relatives, friends, or neighbors. Almost 67 percent rely solely on unpaid help, primarily from wives and adult daughters. As disability increases, elders receive more and more informal care. Some 86 percent of elders with three or more limitations in activities of daily living reside with others, receiving 60 weekly hours of informal care and a little more than 14 hours of paid assistance. Almost 75 percent of the primary caregivers are women; 36 percent are adult children; 40 percent are spouses.[29] It has been estimated that between 30 and 38 million adult caregivers provided care to adults with limitations in 2006.[30]

Formal Care Providers. While the physician is the primary health professional in acute care and often supervises formal care, nurses provide the majority of skilled services in long-term care. In 2005, there were an estimated 2.9 million

registered nurses (RNs); including 260,000 employed in long-term care settings. One study of nursing home staffing found the annual turnover rate among directors of nursing and other RNs was about 50 percent; 15 percent of RN positions were vacant.[31] Often taking a supervisory role, licensed practical nurses (LPNs) represent the vast majority of nurses in long-term care. Of the estimated 760,000 active LPNs, about 271,000 work in long-term care settings.[32]

Otherwise, most paid providers of long-term care are the direct care workers who are the frontline caregivers. These workers – certified nursing assistants, home health or home care aides, personal care workers, and attendants – deliver most of the hands-on, low-tech personal care and assistance with daily life. They are also the eyes and the ears of long-term care as well as the "high touch" providers in all long-term care settings.[33] There are an estimated 1.4 million nurse aides, half of whom work in nursing homes, with the other half working in other residential care arrangements. There are 615,000 home health and personal care aides, including 205,000 who work for home health agencies and another one-fifth who are employed by residential long-term care providers.[34]

To become certified as a nurse aide, federal law requires less than two weeks of training or passing a certification exam, although most states add to these requirements. Home health aides must pass a federally mandated competency exam for their employers to receive reimbursement from Medicare. Federal continuing education requirements for home health aides and nurse aides are minimal, and the content is left to the states and providers. The states determine the regulation of other direct care workers, including those who work in assisted living, for home care agencies, or are independent providers. Typically, the staff in these settings receives little or no training.[35]

Self-employed home care workers are hired directly by consumers to provide personal assistance services and other supportive tasks. The size of the self-employed home care workforce may be at least 134,000, a figure that probably underestimates the number of workers not captured by national databases. An

increase in self-employed home care workers has been stimulated by federal and state support of consumer-directed models of service delivery that enable care recipients to hire, direct, and fire their own home care workers. In some states, these consumer-directed models also enable care recipients to employ members of their family to provide needed care.[36]

Recruiting and, more importantly, retaining direct care workers have become major issues for providers, workers, consumers, and policy makers at the state and federal levels.[37] While the magnitude and distribution of workforce shortages cannot be accurately assessed, there is considerable evidence that shortages confront the long-term care system. A survey of states found two-thirds reported shortages of certified nursing assistants and 60 percent reported shortages of home health aides.[38]

The success of efforts to recruit, retain, and maintain a direct care workforce is dependent on a variety of interdependent factors including: the value that society places on caregiving; local labor market conditions, including wage levels and the degree of unemployment; long term-care regulatory and reimbursement policies; federal, state, and local workforce resources targeted to this sector; and immigration policy. The confluence of these factors and individual employer and employee decisions are played out in the workplace. Organizational philosophy and management style, wages and benefits, quality of the work environment, and interpersonal dynamics affect the successful development of the direct care workforce.[39]

At the policy level, states have experimented with a number of interventions including Medicaid "wage pass-throughs" that require any Medicaid reimbursement increases to go directly to direct care workers, expanded health insurance coverage, enhanced training programs focusing on life skills and clinical knowledge, and the development of new labor pools, e.g., older workers, former welfare recipients. Providers have implemented a range of interventions including culture change activities to create a healthier work and care environ-

ment, peer mentoring programs, career ladders for professional development and promotion opportunities, and supervisory and communication training. The federal Department of Labor included the development of the direct care workforce in its recent "high economic growth" initiative, and has awarded several grants to help create and test new models of long-term care worker training, support, and professional growth.

We know that direct care, for the most part, requires little education and training. The "soft skills" of these workers may be quite extensive, but they are rarely acquired through formal channels. There are few training or certification requirements for direct care workers outside of employment paid for with government funds. Federal law requires that nurse aides have at least 75 hours of training for the employer to receive reimbursement for their services from Medicare and Medicaid plans. They must pass a competency evaluation or state certificate exam, and have at least 12 hours per year of continuing education. Even fewer regulatory requirements pertain to home health aides and personal care aides who are not covered under Medicare and Medicaid. Many of these workers have only completed a high school education, and some have less than a high school education. Aside from self-reporting in the census, there are no mechanisms for acquiring data and human capital information of home health aides within the United States.

IMMIGRATION POLICY AND THE CARE SECTOR

The United States has few dedicated avenues of legal admission that select for professional care workers and none that target direct care workers. The three principal avenues of admission into the U.S. workforce are legal permanent admissions, temporary legal admissions, and unauthorized migration. This section provides a brief overview of each of these admission routes and then discusses their adequacy as vehicles for admission of health and social care workers. It concludes with a discussion of the accreditation of foreign health professionals who are admitted to the United States.

Legal permanent admissions

Permanent immigrants, also known as "green carders," are persons who are entitled to live and work permanently in the United States and, after five years, to become naturalized U.S. citizens. The four principal doors for legal permanent admission are family reunification, humanitarian interests, employment, and diversity. By far the largest admissions door is for relatives of U.S. residents. In 2008, the last year for which there is detailed statistics, 716,244 (65 percent) of the 1,107,126 million immigrants were granted entry because family members formally petitioned the government to admit them. Immigrants and their family members admitted for employment reasons represented 15 percent of admissions. The third largest category of immigrants included refugees, asylees, and other humanitarian admissions (15 percent), and a very small percent came under the so-called diversity visa category (4 percent).

Family reunification

The family category encompasses several sub-categories. The spouses, minor children, and parents of U.S. citizens may enter without regard to any numerical limitations, as long as their sponsors are able to demonstrate a capacity to support them. Numerically capped admission categories are available for the unmarried adult children of U.S. citizens, the spouses and unmarried children of legal permanent residents who have not been naturalized, the adult married children of U.S. citizens, and the brothers and sisters of U.S. citizens. In each of the adult categories, the principal applicants may enter with their spouses and minor children. Obviously, many family immigrants are employed, some as professional workers, but a majority are in jobs requiring low-to-average skills such as direct health care.

Humanitarian interests

Humanitarian admissions include refugees who were resettled from overseas as well as those who sought asylum having entered the United States on their

own. Among the refugees and asylees are health and social care workers, but the principal criteria for admission focus on their claims of persecution, not their employment potential. In addition, legal permanent status has been authorized to members of certain nationalities on a humanitarian basis, such as Cubans, Nicaraguans, Salvadorans, Guatemalans, and Haitians. Some of these individuals are also health and direct care providers. In fact, some of the vocational training programs supported by the federal Office of Refugee Resettlement (ORR) have focused specifically on training health and direct care workers.

Employment

The employment-based immigration category is divided into five preferences, or groupings, each with its own admission ceiling. The top preference goes to priority workers or persons of extraordinary ability, primarily academics or executives of corporations. The second group includes professionals with advanced degrees and workers of exceptional ability. The third group is composed of other professionals or skilled workers, as well as 10,000 low-skilled workers. A fourth class permits the entry of religious workers. The fifth group includes entrepreneurs. Most employment-based immigrants are sponsored by employers and about 90 percent are already in the United States.[40] Thus, most employment-related visas are for highly skilled workers and apply only to professional health care providers.

Diversity

The diversity visa class of permanent visas was created in order to provide a channel for the admission of individuals from countries that are otherwise under-represented in the immigration stream. Applicants are chosen on the basis of a lottery from designated countries. They must meet the usual qualifications and, in addition, have completed at least a secondary education. In practice, little is known about this class of admission other than it admits

migrants who are somewhat better educated than, say, many family stream immigrants and, for example, admits many immigrants from Africa. It is unknown how many of these diversity immigrants work in health care.

Temporary work programs

Legal temporary worker categories are increasingly important as the vehicle for admission of foreign workers, particularly professionals, executives, and managers. The visa categories are referred to by the letter of the alphabet under which it is described in the Immigration and Nationality Act. The principal sections under which skilled temporary workers enter are the E visa for traders and investors entering under bilateral treaties, H1-B for highly skilled specialty workers, H-1C for nurses in shortage areas, L for intercompany transfers, and J for exchange scholars among several others. Lesser-skilled temporary workers are admitted as H-2A seasonal agricultural workers and H2-B workers in jobs that are seasonal, intermittent, supply a peak load need, or a one-time occurrence. These latter jobs are double temporary, e.g., the job needs to be temporary and the migrant must intend a temporary stay.[41]

The H visas supply the greatest share of temporary workers. In the Immigration Act of 1990 Congress imposed annual numerical caps of 65,000 on new H-1Bs and 66,000 on new H-2Bs. Until the economic crisis, employer demand for both H-1Bs and H-2Bs had been such that applications for the numerical cap were exceeded before the year ran out. Although applications decreased in 2009, they are expected to rebound when job growth resumes. The H-1B visa now permits an additional 20,000 visas for foreign graduates in sciences and engineering fields from U.S. institutions, as well as unlimited numbers for sponsoring employers in the non-profit sector. Exemptions to previously employed H-2B workers allowed the cap to be exceeded from 2005 to2007, but have not been reinstated. The skill requirements for the H-2B make it relevant for direct care providers, but applications are likely to be rejected because the work is not necessarily temporary in nature.

Unauthorized migration

While legal admissions for employment favor skilled workers with employer sponsorship, and most low-skilled immigrants are sponsored through family channels and find employment subsequent to admission, unauthorized workers enter predominantly for work in low-skilled jobs. Estimates rely on the so-called residual method which subtracts the known legal population from total population counts to yield the total unauthorized population. As of 2008, there are estimated to be 11.9 million unauthorized migrants or about 30 percent of all foreign born.[42] It is estimated that 8.3 million of the unauthorized population is employed and most of these are in low-skilled jobs such as farming, grounds keeping, and construction. Until the economic crisis, the net growth of the total unauthorized population was about 400,000 annually and, as a net number, it reflected the difference between new entries and those who return home or who adjust their status and become legal immigrants. Growth in the number of entrants appears to have abated in the past year with the advent of the recession and downturn in construction, but as with temporary work programs unauthorized entry is likely to resume when the economy improves.

Unauthorized entry occurs in a number of different ways. About 55 percent of those illegally in the United States are believed to have entered clandestinely, largely across the land border with Mexico, although others arrive by sea often in makeshift boats or rafts. About 45 percent enter through recognized ports of entry. Some do so with fraudulent documents; counterfeit passports, visas, and other identity documents may be used. Still others enter having obtained legitimate visas, often as tourists, and then overstay the period that the visa covers. In other cases, the migrants enter as temporary workers but fail to leave when their period of work authorization ends. Like legal migrants who are admitted on family-sponsored visas, some of whom may have originally been unauthorized migrants, it is likely that most currently unauthorized workers find their way into long-term care jobs after coming to the United States. The number of LTC workers who are in an unauthorized status can be estimated;

we discuss those estimates below in this report. It is ironic that the available estimates of stock permit us to estimate workers in an unauthorized status, but we can glean a sense of legal class or visa of admission only through the yearly flow or admissions data.

Data on admissions in the health care sector

The major avenue of entry for skilled health care workers, as well as for most of the lesser-skilled health care workers, is via the permanent admission class. Most low-skilled workers are more likely to enter via family reunification, refugee, and diversity categories as they are to come through the employer-sponsored programs. The permanent and temporary classes of admission admit substantial numbers of professional health care providers, but do not target lesser-skilled providers.

On permanent visas, the available administrative data suggest some year-to-year variation in the admission of professional health care workers. About 1.5 times as many nurses are admitted as physicians. From 1991 to 1996, the total number of nurses admitted averaged 8,564, while from 1997 to 2000 the number of nurses fell to an annual average of 4,815.[43] However, the numbers in the employment classes alone grew again to 6,625 in 2004; as two-thirds of nurses enter on employment visas, this suggests that as many as 9,800 nurses were admitted. Yet, more recent data are unavailable and they remain mute as to the number of direct care workers who, after all, likely find their way into eldercare after coming to the United States with other employment in mind.[44]

The specialty H-1B visa is, doubtless, the best known temporary visa. Some 7,022 practitioners and 4,102 other medical workers were admitted through the H-1B program in 2005 (last date available). The H-1B visa requires that the worker being sponsored for the position has at least a bachelor's degree, which is not a requirement for registered nurses in most states. This makes the H-1B visa appropriate for nurse practitioners and certain specialties that require the additional education (e.g., operating room nurses). Other options include the

EB-3 visa recently developed for Australia with a cap of 10,000 visas and an unknown number filled by nurses. Finally, the TN or Trade NAFTA temporary work program admitted perhaps 20,000 to 30,000 individuals in 2007, predominantly from Canada, and while precise numbers are unknown, anecdote suggests that a substantial number of Canadian nurses are admitted.[45]

There have been small-scale efforts by the U.S. Congress to increase the admission of foreign nurses and physicians. The Nursing Relief Act of 1989 created a pilot program of H-1A temporary worker visas for foreign-trained nurses. The H-1A program required hospitals, nursing homes, and other sponsors to attest that:

> (A) There would be a substantial disruption through no fault of the facility in the delivery of health care services of the facility without the services of such an alien or aliens.
>
> (B) The employment of the aliens will not adversely affect the wages and working conditions of registered nurses similarly employed.
>
> (C) The aliens employed by the facility will be paid the wage rate for registered nurses similarly employed by the facility.
>
> (D) Either (1) The facility has taken and is taking timely and significant steps designed to recruit and retain sufficient registered nurses who are United States citizens or immigrants who are authorized to perform nursing services, in order to remove as quickly as reasonably possible the dependence of the facility on nonimmigrant registered nurses, or (2) The facility is subject to an approved State plan for the recruitment and retention of nurses.
>
> (E) There is not a strike or lockout in the course of a labor dispute, and the employment of such an alien is not intended or designed to influence an election for a bargaining representative for registered nurses of the facility.

The program was designed to fill what was believed to be a short-term nursing shortage by giving facilities access to foreign nurses while requiring them to take steps to recruit and retain U.S. citizens or already resident immigrant nurses.

Sponsors could show good faith efforts to recruit and retain by operating a training program for nurses at the facility or financing (or providing participation in) a program elsewhere, providing career development programs and other viding "reasonable opportunities for meaningful salary advancement" by RNs.

The H-1A program expired in 1995 after admitting 6,512 nurses. A successor program, the H-1C program, went into effect in 1999. The H-1C program has many of the same recruitment and retention requirements, but the visas of the new program are designed just for nurses sponsored by hospitals in medically underserved areas and have been capped at 500 visas annually.[46] A similar requirement also applies to the J visa for foreign medical graduates in medically underserved areas, which permits physicians who would otherwise be required to return home to remain within the United States to practice medicine.[47]

Accreditation of foreign health professionals

The admission of professional caregivers is affected by accreditation practices governed both by non-governmental bodies and state government policies. Physicians who are Foreign Medical Graduates (FMGs) cannot practice medicine until they fulfill a number of accreditation requirements. First, they must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG), which verifies their medical education credentials directly with their medical schools. They must also pass the U.S. Medical Licensing Examination, which tests medical science knowledge and clinical knowledge and skills. After completing the ECFMG certification, the foreign physicians must complete an accredited residency training program in the United States, which takes three or more years. The final step is to apply for a state license to practice medicine.

Similarly, the CGFNS International (formerly the Commission on Graduates of Foreign Nursing Schools) provides an accreditation process for other health professionals. Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 requires that internationally educated health care professionals – such as registered nurses, licensed practical or vocational nurses,

physical therapists, occupational therapists, physician assistants, speech pathologists and audiologists, and various medical technicians – who are seeking temporary or permanent employment-based visas to first obtain a certificate from CGFNS. This process is undertaken before a visa is issued. The CGFNS Certification Program (CP) is comprised of three parts: a credentials review, which includes an evaluation of secondary and nursing education, registration, and licensure; a qualifying examination that tests nursing knowledge; and an English language proficiency examination. The nurses must also take licensure examinations in the states in which they plan to practice.

THE FOREIGN-BORN WORKFORCE IN LONG-TERM CARE

There is a small body of research using data on LTC workers, but surprisingly little of it tells us much about the foreign born. We use the large samples of the U.S. population taken by the U.S. Census Bureau that are known as the American Community Surveys (ACS) to examine the characteristics of the foreign born in LTC. We are able to identify LTC with codes that identify more detailed occupation and industry employment before the ACS surveys began in the year 2000. We are able to consider the range of LTC occupations by combining occupation and industry identifiers. In order to get a sufficient sample size, we combine or average results in many cases for the five years from 2003 to 2007.

The long-term care workforce

We follow prior research to define direct care workers with selected occupations restricted to LTC industries, but we expand our examination here to professional care workers in a smaller subset of LTC industries. Like others, we consider lower-skilled direct care providers to include the occupational titles of nursing psychiatric and home health aides, as well as personal and home health aides. Professional care workers are employed in occupations titled practitioners (physicians and dentists, etc.), nurses, or therapists. Direct care workers are, by definition, in LTC so we consider any employment in one of the seven LTC

industries. We define professional care workers as being found in LTC in five of these industries, excluding those employed in outpatient care or in hospitals.

Table 1 shows employment shares by occupation in the long-term care sectors for direct and professional care. The lower panel demonstrates that, for all native and foreign-born LTC workers combined, most are in nursing care facilities (40 percent) and home health care services (25 percent). Formal employment in long-term care is found primarily in these industries, while a large labor force of informal family members that cannot be identified with these data labor "off the books" in private households or family services. At the same time, the 16 percent of LTC workers apparently employed in hospitals is largely due to the mixed nature of the occupational grouping "nursing, psychiatric, and home health aides," which includes LTC workers with aides not so clearly identified. Long-term care, by and large, does not take place in either hospitals or outpatient services.

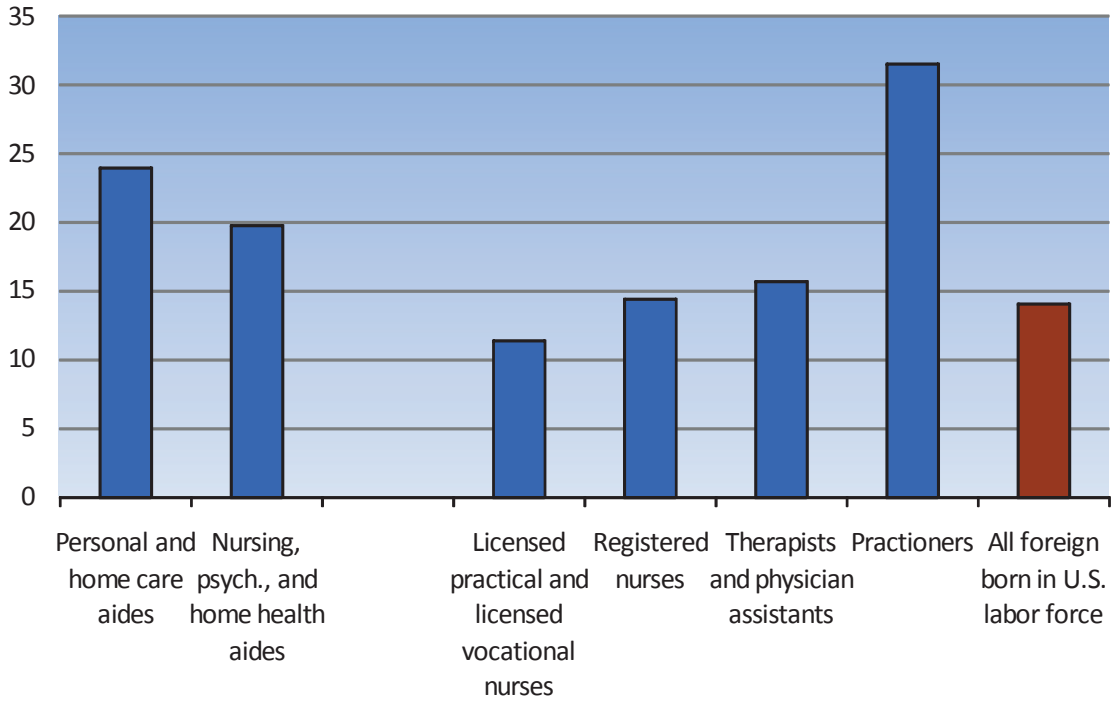
Figure 1 shows the percent of workers in LTC jobs that are foreign born. The greatest concentration of foreign-born workers is in practitioner jobs, i.e., physicians, dentists and surgeons, as is the case outside of long-term care. Nearly one-third, 32 percent, of LTC practitioners are foreign born, but practitioners are less than 1 percent of the entire LTC workforce. On the other hand, the foreign born are 24 percent of home health aids and 20 percent of nursing and psychiatric aides, sectors that employ about 80 percent of the total LTC workforce. The foreign born are under-represented as licensed nurses, 11 percent compared with the 14 percent of immigrants in the total U.S. labor force. The foreign born are also not a particularly high proportion of registered nurses or therapists. Thus, immigrants are disproportionately concentrated in the low-skill direct care jobs that dominate the long-term health care sector. Note, however, that the concentrations of foreign born can be markedly higher in certain occupation-and-industry sectors especially for professional care. As table 1 showed, the share of foreign workers is greatest in the private household sector, particularly in the more skilled nursing jobs within that sector where they supply 48 percent, nearly half, of all registered nurses.

Table 1: Long-term care workers by occupation, industry, and nativity (2003-2006)

Industry	Direct care		Professional care occupations				Total
	Personal & home care aides	Nursing, psych., & home health aides	Licensed practical & licensed vocational nurses	Registered nurses	Therapists & physician assistants	Prac-tioners	
Immigrant share of occupation-and-industry workforce (%)							
Total	23.9	19.8	11.4	14.5	15.8	31.5	19.3
Private households	25.6	34.6	36.0	47.6	--	--	27.3
Individual and family services	28.9	28.8	9.1	9.7	8.4	--	27.2
Home health care services	24.3	27.3	10.3	9.3	13.2	--	23.0
Residential care, no nursing	17.4	14.6	13.4	13.1	16.0	--	15.9
Nursing care facilities	24.5	16.9	11.4	17.2	17.5	35.3	16.3
Outpatient care centers	6.7	14.1	--	--	--	--	13.0
Hospitals	18.0	17.9	--	--	--	--	17.9
Share of total occupational workforce within industry (%)							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private households	19.5	1.1	0.7	0.5	--	--	4.6
Individual and family services	20.4	2.6	1.6	3.1	3.4	24.2	6.1
Home health care services	31.4	22.2	14.9	31.3	32.3	16.2	24.5
Residential care, no nursing	17.6	5.1	3.5	3.8	16.1	14.7	7.5
Nursing care facilities	7.7	40.2	79.4	61.3	47.6	44.9	39.5
Outpatient care centers	1.4	2.6	--	--	--	--	1.8
Hospitals	1.9	26.2	--	--	--	--	15.9
Occupation workers (%)	19.8	59.4	8.7	10.3	1.7	0.1	100.0
Occupation workers (1,000s)	578	1,730	253	300	49	4	2,913

Source: Tabulations of the American Community Survey.
Note: -- sample size less than 30 observations or, for professional care workers, work in outpatient care and hospitals is not considered long-term care.

Figure 1: Percent of long-term care workers who are foreign born, 2003-2007



Source: Tabulations of American Community Survey

These figures so far include both legal and unauthorized workers who cannot be separately identified in official U.S. survey data. Thus, we obtained separate estimates by legal status which show that legal entrants make up the bulk of the foreign born in the professional long-term care workforce, while unauthorized workers are a substantial percentage of the direct care workforce.[48] The unauthorized eldercare workforce can be estimated by an imputation that uses country of birth, time of arrival, and individual characteristics that are known to be associated with unauthorized status. The method includes a degree of error, but it generates reliable estimates that are consistent with the observation of experts. As of 2008, it is estimated that the unauthorized are 3 percent of foreign-born professional workers and 21 percent of the foreign-born direct care workers in the long-term care of the elderly. So the unauthorized are an extremely small percentage of foreign-born professionals and a minority of direct caregivers. At the same time, while all unauthorized workers are a little

more than roughly 5 percent of the total U.S. labor force, they are less than 0.5 percent of *all* native- and foreign-born professionals and just 4 percent of *all* direct care workers in long-term care. This likely reflects the legal admission, as well human resource employment procedures in larger institutions that screen unauthorized professional workers. Unauthorized workers are more successful at finding employment in the lesser-skilled and lower paying direct care workforce, but they are not disproportionately concentrated in these jobs.

Characteristics of foreign-born care workers

We examine next various characteristics of foreign-born workers. First, we are interested in where foreign-born workers come from, that is where they are born. Table 2 shows that direct and professional care workers come from different countries and that the greatest share of workers from any country of birth is found in direct care and not in professional care occupations. For example, the first set of columns shows that 78 percent of the native-born and 86 percent of the foreign-born workers are in direct care. But the concentration in direct care jobs differs by nationality and fully 95 percent of Mexican workers are direct care providers as contrasted with 70 percent of Filipino workers, 66 percent of workers from England, and just 59 percent of Canadians.[49] But while there is notable variation among immigrant groups, long-term care is predominantly about the provision of frontline, direct care which is the largest occupational group compared with professional caregivers.

The second set of columns in Table 2 shows the share of the total U.S. workforce made up by each nationality – the foreign born are 21 percent of direct caregivers and a lesser 13 percent of professionals. A majority of foreign-born direct caregivers come from the Western Hemisphere, while professional care workers are more diverse albeit Asia supplies a significant share of these highly skilled workers. Among foreign-born professional care workers 37 percent come from Asian countries, 25 percent from the Philippines alone, while another 22 percent come from the Caribbean islands and just 12 percent from Latin America. Africa is the source of another 15 percent, while Canada and Europe together

supply just 13 percent of professional care workers. English-speaking countries combined supply only 16 percent of professional care workers, while countries where English is prevalent, India and the Philippines, supply another 30 percent. In comparison, among foreign-born direct care workers there is somewhat more diversity with only roughly one-quarter coming from countries where English is spoken. Half of foreign direct care workers come from the Western Hemisphere; 29 percent from the Caribbean and 21 percent from Mexico and Central America. Mexico alone supplies 15 percent of direct care workers and Jamaica and Haiti supply another 17 percent.

Table 2: Selected countries of birth of foreign-born long-term care workers (2003-2007)

Region and nation of birth	(1) Share in each occupational group by nationality, %			(2) Share of total U.S. workforce, %		(3) Total count
	Direct care workers	Professional care workers	Total	Direct care workers	Professional care workers	
Total	79.2	20.8	100.0	100.0	100.0	2,917,229
U.S. born	77.7	22.3	100.0	79.1	86.6	2,351,748
Foreign born	85.6	14.4	100.0	20.9	13.4	565,481
Foreign born	85.6	14.4	100.0	100.0	100.0	565,481
Canada	59.0	41.0	100.0	0.7	3.1	6,072
Mexico & Central America	95.0	5.0	100.0	21.3	6.7	108,689
Mexico	95.3	4.7	100.0	15.3	4.5	77,645
El Salvador	95.6	4.4	100.0	2.4	0.7	12,080
Guatemala	96.8	3.2	100.0	1.1	0.2	5,665
Honduras	95.8	4.2	100.0	1.0	0.3	5,254
Nicaragua	93.5	6.5	100.0	0.7	0.3	3,475
Caribbean & Atlantic Islands	88.7	11.3	100.0	29.0	21.9	158,187
Jamaica	88.3	11.7	100.0	9.0	7.1	49,348
Haiti	85.9	14.1	100.0	8.1	7.9	45,721
Dominican Republic	95.4	4.6	100.0	5.0	1.4	25,376
Trinidad and Tobago	90.9	9.1	100.0	2.2	1.3	11,933
Cuba	88.1	11.9	100.0	1.5	1.2	8,022

Table 2 (continued)

Region and nation of birth	(1) Share in each occupational group by nationality, %			(2) Share of total U.S. workforce, %		(3) Total count
	Direct care workers	Professional care workers	Total	Direct care workers	Professional care workers	
South America	88.3	11.7	100.0	6.9	5.4	37,888
Guyana/ British Guiana	86.1	13.9	100.0	2.5	2.4	13,985
Colombia	88.6	11.4	100.0	1.4	1.1	7,470
Peru	90.7	9.3	100.0	1.1	0.6	5,627
Ecuador	93.8	6.2	100.0	0.8	0.3	3,992
Europe	85.5	14.5	100.0	10.0	10.1	56,638
Poland	85.8	14.2	100.0	1.5	1.4	8,318
Ukraine	89.3	10.7	100.0	1.4	1.0	7,440
Russia (other USSR)	89.1	10.9	100.0	1.3	1.0	7,323
Germany	75.8	24.2	100.0	0.7	1.3	4,354
England	66.3	33.7	100.0	0.5	1.6	3,975
Romania	89.7	10.3	100.0	0.6	0.4	2,970
Ireland	79.8	20.2	100.0	0.2	0.3	1,411
Asia	74.8	25.2	100.0	18.5	37.1	119,936
Philippines	69.8	30.2	100.0	9.7	25.0	67,181
India	61.5	38.5	100.0	1.4	5.1	10,683
China	90.8	9.2	100.0	1.9	1.1	10,000
Vietnam	90.1	9.9	100.0	1.2	0.8	6,239
Korea	78.7	21.3	100.0	0.7	1.1	4,098
Africa	82.3	17.7	100.0	11.7	15.0	68,979
Nigeria	76.0	24.0	100.0	2.3	4.3	14,698
Africa, ns/nec	82.8	17.2	100.0	1.8	2.2	10,358
Ghana	88.7	11.3	100.0	1.6	1.2	8,799
Liberia	86.0	14.0	100.0	1.4	1.4	8,028
Kenya	86.5	13.5	100.0	1.2	1.2	6,972
Ethiopia	80.3	19.7	100.0	0.7	1.0	4,010
Oceania	94.0	6.0	100.0	0.9	0.3	4,546

Source: Tabulations of the American Community Survey.
Notes: Average population for the 2003-2007 period. Total observations under 100 excluded.

Once again, the foregoing combines legal and unauthorized workers. But estimates of unauthorized long-term care workers loosely parallel what we know of their distribution in other occupational groupings.[50] Among foreign-born professional care workers, less than 3 percent are unauthorized with 52 percent of this very small percentage being from Asian origins, 10 percent from the Caribbean, and just 9 percent from Mexico and Central America. Among foreign-born direct care workers, some 21 percent are unauthorized but only 20 percent are from Asia, 18 percent from the Caribbean, 33 percent from Mexico and Central America, and another 20 percent are from Africa. There are few unauthorized workers in professional care, while more of the lesser-skilled direct care jobs employ unauthorized workers from the Western Hemisphere. Unauthorized professional care workers tend to be from Asia, while Latino and Caribbean workers are the single largest group of unauthorized direct caregivers. Perhaps most unanticipated is the one-fifth of unauthorized direct care workers who are from African origins.

After arriving in the United States, and again turning to figures combining legal and unauthorized status, all immigrants in long-term care jobs reside, and surely work, in very different places than natives. First note that, unsurprisingly based on what we know about immigrants generally, the foreign-born workers tend to live in metropolitan areas, about 96 percent compared with just 73 percent of native long-term care workers. While we cannot tell precisely, these data also suggest that foreign long-term care workers are considerably more likely to live within the central cities of metropolitan areas.[51] But the foreign-born long-term care workforce lives in different cities than other immigrants. In fact, the second set of columns in table 3 shows that somewhere between two-thirds (professionals) and three-quarters (direct caregivers) of the foreign-born live in just 24 metropolitan areas. Surprisingly, roughly one-quarter of all foreign-born long-term care workers reside in the New York metropolitan area.[52] In contrast, the first set of columns in table 3 show that just one-quarter of native workers are found in their top 24 places of residence and, while New York is their top city, only one in 25 native long-term care workers reside there. At the same time, table 3 shows the foreign-born percentage of the entire long-

term care workforce within each metropolitan area and – often regardless of whether the list is of top foreign- or native-born areas – that percentage is often significant. Migrants are, for example, 66 percent of long-term care workers in New York City, 29 percent in Chicago, and 63 percent in Los Angeles.

Table 3: Percent of long-term care workers by place of residence and nativity, and the immigrant share of the metropolitan workforce (2005-2007)

(1) Top 24 native-born metropolitan areas (% of all natives in each metropolitan area)			
Metropolitan area	Direct care	Professional care	Foreign-born share
Total metropolitan count (1,000s)	1,887	540	--
Total metropolitan share (percent)	100.0	100.0	19.8
New York-Northeastern NJ	3.5	3.2	65.8
Chicago, IL	2.2	1.9	29.2
Detroit, MI	1.8	1.1	9.4
Philadelphia, PA/NJ	1.7	2.8	17.2
Los Angeles-Long Beach, CA	1.6	1.1	63.1
St. Louis, MO-IL	1.3	1.1	2.2
Dallas-Fort Worth, TX	1.2	1.1	18.1
Minneapolis-St. Paul, MN	1.1	1.3	22.7
Pittsburgh, PA	1.1	1.3	3.9
Houston-Brazoria, TX	1.1	1.0	22.8
Cleveland, OH	1.0	1.4	6.4
Boston, MA-NH	0.9	1.7	38.6
Riverside-San Bernardino, CA	0.9	0.5	33.3
Baltimore, MD	0.8	1.1	13.9
San Francisco-Oakland-Vallejo, CA	0.8	0.5	57.5
Atlanta, GA	0.8	0.7	23.1
Phoenix, AZ	0.8	0.9	21.1
Milwaukee, WI	0.7	0.6	4.0
Tampa-St. Petersburg-Clearwater, FL	0.7	1.0	22.4
Washington, DC/MD/VA	0.6	0.6	55.0
San Antonio, TX	0.6	0.5	16.0
Greensboro-Winston Salem, NC	0.6	0.5	1.7
Cincinnati-Hamilton, OH/KY/IN	0.6	0.9	3.0
Buffalo-Niagara Falls, NY	0.6	0.7	1.5

Table 3 (continued)

(2) Top 24 foreign-born metropolitan areas (% of all immigrants in each metropolitan area)			
Metropolitan area	Direct care	Professional care	Foreign-born share
Total metropolitan count (1,000s)	512	85	--
Total metropolitan share (percent)	100.0	100.0	19.8
New York-Northeastern NJ	28.1	21.5	65.8
Los Angeles-Long Beach, CA	10.5	8.1	63.1
San Francisco-Oakland-Vallejo, CA	4.1	2.3	57.5
Chicago, IL	3.2	5.5	29.2
Washington, DC/MD/VA	2.8	5.3	55.0
Boston, MA-NH	2.7	2.9	38.6
Miami-Hialeah, FL	2.5	2.5	73.6
Fort Lauderdale-Hollywood, FL	1.9	2.2	67.4
Riverside-San Bernardino, CA	1.6	1.7	33.3
San Diego, CA	1.5	1.4	45.3
Philadelphia, PA/NJ	1.5	2.6	17.2
Seattle-Everett, WA	1.5	1.4	46.8
Houston-Brazoria, TX	1.3	0.8	22.8
Minneapolis-St. Paul, MN	1.3	1.6	22.7
San Jose, CA	1.1	1.4	69.4
McAllen-Edinburg-Pharr-Mission, TX	1.1	--	48.5
Sacramento, CA	1.0	--	40.5
Dallas-Fort Worth, TX	1.0	1.4	18.1
West Palm Beach-Boca Raton, FL	0.9	1.2	54.6
Phoenix, AZ	0.9	0.8	21.1
Atlanta, GA	0.8	1.3	23.1
Tampa-St. Petersburg-Clearwater, FL	0.8	--	22.4
Brownsville-Harlingen-San Benito, TX	0.7	--	46.9
Orlando, FL	0.7	1.1	38.7

Source: Tabulations of the American Community Survey.
Notes: -- sample size less than 30. Sorted by size of direct care workforce, separately by nativity. Foreign-born share is the immigrant percent of all LTC workers in the metropolitan area.

There is a very high correlation between the number of elderly and the corresponding long-term care workforce in America's metropolitan areas.[53] For example, the greatest number of America's elderly population 65 years of age and older live in New York followed closely by Los Angeles, Chicago, Philadelphia, and so forth; not surprisingly, these are the cities with the largest long-term

care workforces. However, we cannot readily explain why immigrants are hyper-concentrated in New York. At this juncture we would only observe that the foreign-born workforce also tends to be a very high percentage of the city's total long-term care workforce in almost all of the top foreign-born metropolitan areas. What is more, when looking at individual metropolitan areas, rather than just the national statistics, it becomes obvious that migrants supply the majority of caregivers in select metropolitan areas. These are surely issues for future research.[54]

Table 4 shows the demographic characteristics of LTC workers by nativity. The foreign-born are slightly less likely to be female than are natives, 77 compared with 81 percent, but regardless long-term care workers are overwhelmingly female. Foreign-born workers are ever so slightly older than natives, 45 versus 44 years on average, making this combined workforce somewhat older than many other occupational groups. Other than the nature of the occupation, the older age of migrants is also associated with the fact that the long-term care foreign born have been in the country a relatively long time, only 27 percent having arrived in the country in the prior 10 years compared with 40 percent of the U.S. foreign born on average. This may be, in turn, associated with the relatively high rates of citizenship; 59 percent of foreign-born long-term care workers are naturalized compared with about 42 percent of the foreign born on average.[55]

A particularly high proportion of physicians or practitioners (81 percent) are naturalized. It appears that foreign- and native-born long-term care workers have similar average years of education; about 15 years on average. Nevertheless, averages can hide differences and we found that the foreign born tend to be somewhat more likely to complete higher degrees than natives. Consistent with licensing requirements, those employed in professional occupations have higher levels of education than those employed in direct care. There does not appear to be a significant "de-skilling" of foreign-born professionals – that is immigrants with higher levels of education working in less-skilled positions.

Table 4: Demographic characteristics of long-term care workers by nativity (2007)

Nativity and occupation	Female	Age	Years of education	Immigrated last 10 years	Naturalized citizen 18 years and older
Foreign-born workers					
Average	76.8	45.2	15.0	27.0	59.3
Personal and home care aides	88.0	47.0	11.7	33.0	44.0
Nursing, psychiatric, and home health aides	86.0	44.0	12.1	34.0	51.0
Licensed practical and vocational nurses	85.0	43.0	13.3	28.0	58.0
Registered nurses	87.0	45.0	15.7	28.0	61.0
Therapists & physician assistants	75.0	41.0	16.3	23.0	61.0
Practioners	40.0	51.0	21.0	16.0	81.0
Native-born workers					
Average	81.3	43.8	15.0	--	--
Personal and home care aides	86.0	43.0	12.3	--	--
Nursing, psychiatric, and home health aides	89.0	38.0	12.4	--	--
Licensed practical and vocational nurses	94.0	43.0	13.2	--	--
Registered nurses	93.0	47.0	15.0	--	--
Therapists & physician assistants	82.0	42.0	16.3	--	--
Practioners	44.0	50.0	20.6	--	--

Source: Tabulations of the American Community Survey.
Note: -- does not apply to native born workers; due to small sample size the estimates for practioners are averaged for 2003-2007.

How do foreign-born workers fare in the LTC labor market? Table 5 shows basic employment conditions for native- and foreign-born workers. The foreign born work more hours than natives averaging 40 hours per week to natives' 37 hours, associated with the fact that 78 percent work full time compared with 72 percent of natives. This tendency of the foreign born to work longer hours holds across all LTC occupations with the exception of practitioners where the hours are the same as natives. But where the foreign born appear little different than natives in the percent self-employed in most occupations, foreign-born practitioners are much less likely than natives to be self-employed.

Table 5: Labor market characteristics of long-term care workers by nativity (2007)

Nativity and occupation	Weekly earnings, average	Unemployed (%)	Usual weekly , average	Full time, hours >= 35 (%)	Self-employed (%)
Foreign-born workers					
Average	$1,139	3.0	39.8	78.3	4.5
Personal and home care aides	$380	7.0	36.0	62.0	12.0
Nursing, psychiatric, and home health aides	$533	4.0	39.0	79.0	3.0
Licensed practical and vocational nurses	$925	2.0	42.0	89.0	0.0
Registered nurses	$1,215	3.0	41.0	86.0	0.0
Therapists and physician assistants	$1,310	1.0	41.0	70.0	5.0
Practioners	$2,473	1.0	40.0	84.0	7.0
Native-born workers					
Average	$906	4.5	36.8	71.8	5.5
Personal and home care aides	$341	9.0	34.0	58.0	12.0
Nursing, psychiatric, and home health aides	$432	7.0	35.0	70.0	2.0
Licensed practical and vocational nurses	$666	4.0	38.0	77.0	0.0
Registered nurses	$916	3.0	38.0	74.0	0.0
Therapists and physician assistants	$956	1.0	36.0	68.0	4.0
Practioners	$2,127	3.0	40.0	84.0	15.0

Source: Tabulations of the American Community Survey.
Note: Due to small sample size the estimates for practioners are averaged for 2003-2007.

Foreign-born workers fare better than natives on basic measures of employment outcomes. Foreign-born workers on average have lower rates of unemployment, 4.2 percent compared with 4.8 percent for natives. Foreign-born professional care workers experience unemployment rates similar to natives, both groups having exceptionally low rates of unemployment. But foreign-born direct care workers have lower rates of unemployment than their native counterparts. At the same time, all direct care workers have rather high rates of unemployment even for 2007 when rates were beginning to increase due to the onset of recession.

The foreign born earn more than natives, $233 per week on average for all long-term care jobs, as well as more in each individual long-term care occupation. Perhaps the foreign born tend to perform better than natives in the labor market because they are slightly older, better educated, and work longer hours. But that is not the case. In a separate analysis, we conducted a regression analysis of migrant-native wage differentials and, holding constant the number of hours worked, experience, language, and the educational differences of migrants and natives, we found that the foreign born still earn significantly more than natives in all LTC occupations.[56] Why the long-term care foreign born earn more than natives is unclear, particularly when immigrants in most other sectors most often earn less than natives after adjusting for experience and skill differentials. It is possible, as our fieldwork suggests, that the foreign born command higher earnings in the long-term care sector because they tend to have longer tenure with their employer or because they work exceptionally well with the elderly.

Whatever the ultimate explanation for the relatively better outcomes of immigrants compared with natives, we should not lose sight of the fact that LTC jobs generally pay somewhat less than other jobs. Direct care workers especially are poorly paid, earning less than the median wage for U.S. workers. They are also less likely to be covered by employment benefits such as health insurance for themselves and their families.[57] On the one hand, these findings suggest that immigrants in long-term care are not experiencing, on average, discriminatory treatment relative to natives. If anything, they are slightly favored over natives. On the other hand, all workers in long-term care could stand better working conditions, employment benefits, and improved wages.

SUPPLY AND RECRUITMENT OF FOREIGN-BORN NURSES

While both physicians and nurses supply the professional care workforce, it is nurses who are its largest component and are the primary supervisors and managers of eldercare. We interviewed more than 30 foreign-born nurses in Arizona individually and in groups in hospital and nursing home settings.

Additionally, we held a group discussion with the officers of two Filipino Nurses Associations in Arizona. In the Washington-Baltimore area, we held a group discussion with 20 Filipina nurses attending a conference of the local chapter of the Filipino Nurses Association; the theme of the conference was recruitment of foreign-born nurses. Filipinas constituted the single largest group of foreign-born long-term care caregivers interviewed both in Arizona and the Washington-Baltimore metro area. This fact, coupled with the U.S.-focused training of professional Filipina caregivers and the perceptions of Philippine culture, may color our findings in unknown ways. However, the remarkable diversity of source countries was also reflected in our fieldwork. We interviewed nurses from many far-flung countries, including Taiwan, China, India, Kuwait, United Kingdom, Russia, Eritrea, Ethiopia, Nigeria, Vietnam, Burma, Finland, Sudan, and Mexico. The nurses reported that there are many pathways by which they come to the United States; one important path is their recruitment by agencies and directly by employers. We interviewed recruiters, as well as nurses and employers who interact with recruiters in Arizona and the greater Washington-Baltimore metropolis.

Migrant nurses' routes into care in the United States

Most of the nurses interviewed for this project came to the United States having been recruited overseas for specific jobs and indicated economic reasons as the main impetus for migrating. Others signed up with local recruitment agencies in their country of origin to explore employment possibilities abroad. In all cases, migrating to the United States required a substantial investment of time and effort. The hurdles included the examinations and other licensing requirements to practice nursing as well as the immigration admissions process.

One of the few male nurses we interviewed, an Irishman, used to be a recruiter in the United Kingdom and during a job fair in London met a nurse recruiter from Arizona. He decided that he was at a point in his career when he would like to take on a new challenge and change jobs. After discussing this matter with his wife, they decided to go ahead with the career change. He said: *Our*

children were at an age where I felt the move would not affect them negatively and it would be a good decision for their future education and opportunities. Thus, he began what became a three year process to complete the NCLEX examinations and get everything in order to move to Arizona. He said*: I anticipated it would be a two year process but I caught the tail end of the 9/11 backlash and the process took three years instead.*

Another male nurse, who was born in Kuwait and educated in Jordan, responded to an advertisement in a Jordanian newspaper from a local recruitment agency that was working with employers in Arizona. Out of some 120 nurses who responded to the recruitment ad, he was the only one to complete the entire process. *It was a big investment of my time,* he said, *but I am happy with my choice. Life is cheaper in the US than in the UK or the Middle East.* He did add, however, that he wished he did not have to go through a third party recruiter and could be recruited directly by his current employer as his wages would have been higher.

Several nurses interviewed for this project did not come to the United States directly from their countries of origin. Several nurses went first to the Middle East. An Indian female nurse, who finished her nursing degree at the age of 23 in India, first went to Dubai with a goal of earning some money and returning to India. She ended up working in a public hospital in Dubai for 25 years; she was in charge of a 25-bed pediatric ward. She was not unhappy with her situation in Dubai; both she and her husband, a lab technician, had good jobs and their children were getting a good education but when she was presented with the opportunity to come to the United States she embraced it as a challenge. She met with a recruiter who had published an announcement in a newspaper and began the paperwork. She did not tell anyone she was studying and preparing to move to the United States.

The first hurdle, she said, *was getting my transcript in order. I had to go back to my American College in India and re-take the coursework and examinations for the psychiatric training portion of my degree. For some reason, that training*

did not appear on my initial transcript, although I had completed it, but there was nothing I could do but re-take it. I completed everything so my school of nursing could send the transcript directly to the recruiters for accreditation.

All of this took a significant amount of resources and time. She did well on her NCLEX test and had no problem with the TOEFL test. She also had to take the IELTS test; she had to go to Saipan to take it. *My second hurdle*, she added, *was a race against the clock in order to get my immigration papers approved because my daughter was turning 21 and everything needed to happen before that or else my daughter couldn't come as a dependent and there was no way that I would consider leaving her behind. I submitted all the paperwork in 2003 and was approved in early 2004, three days before my daughter's 21st birthday. The entire process took over four years from beginning to end!*

A Chinese nurse from mainland China first went to Saudi Arabia because *there is no income tax there*. She had an opportunity to go either to the United Kingdom or to Saudi Arabia, but chose Saudi Arabia because of the income tax exemption. She spent four and a half years in Saudi Arabia to improve her English. She saw many nurses coming to the United States from Saudi Arabia through a process that seemed relatively easy. She spoke with an international recruiter working in Saudi Arabia who helped her with the necessary exams and immigration paperwork. She did not want to use a Saudi Arabia or China-based recruitment agency; she felt many of them are unscrupulous. She preferred working with a recruiter from a hospital in Arizona.

Several Filipino nurses we spoke with came to the United States in late 1970s with a work visa and had to pass the nursing exams while already in the United States. While many of them did pass the required examinations, it often took several attempts to pass the test and receive appropriate scores to be able to practice nursing. Both employers and the foreign-born nurses were frustrated with the length of time it took to finalize the licensing process as the nurses could not work without the license and had to rely on relatives and friends to support them. Employers unanimously agreed that it is better when all the

exams and licensing requirements are fulfilled prior to arrival in the United States.

Many nurses in our study came to the United States to work in nursing, without a particular desire to specialize in elder care. The only exceptions are CNAs and LPNs who look for work in assisted living facilities and nursing homes. Some nurses ended up working with elderly patients because they work in areas—such as Arizona—where there are a lot of elderly. One recruiter in Arizona said: *Sooner or later they will all work with elderly. Phoenix and Tucson attract many retirees, so whether they* [the nurses] *work in primary care or in geriatrics, they have to be able to serve older people.* Several nurses we interviewed work in elder care because they want to augment their income and get a second, usually part-time, job in a nursing home or as an in-home personal care manager. Shift work allows for these creative strategies to enhance one's income.

Employer recruitment processes

Our fieldwork in Arizona and in the Washington-Baltimore metro area indicates that employers use a variety of strategies to recruit foreign-born nurses, including direct recruitment by in-house recruiters, recruitment by third-party firms, and word of mouth strategies. Most employers use a combination of strategies. Large hospitals and health care systems tend to rely on a mixture of direct recruitment from abroad by in-house recruiters and third-party recruiters. Smaller health care facilities use mainly third-party recruiters, while many nursing homes seem to rely solely on word of mouth strategies.

A 2006 survey conducted by the Commission on Graduates of Foreign Nursing Schools (CGFNS) of recently arrived foreign-born and foreign-educated nurses found that 41 percent of them were recruited in their home countries, up from 35 percent in a 2003 National Council Licensure Examination (NCSBN) survey. Among those recruited from abroad, the CGFNS survey found that direct recruitment by hospitals was slightly more common than recruitment by third-party agencies.

According to the 2007 report on *U.S.-Based International Nurse Recruitment* (Pittman *et. al.* 2007), there were 267 U.S.-based recruitment firms, representing a ten-fold increase from what recruiters called "a cozy niche" of about 30 to 40 recruitment agencies in the late 1990s. The report indicates that recruiters operate in 74 countries and most plan to expand both the number of nurses they bring to the United States and the number of countries in which they recruit. Our fieldwork corroborates these findings. Additionally, interviews with recruiters suggest that they are also branching out to recruit foreign-born physical therapists, particularly to work with middle age and elderly patients who have recently undergone major surgeries or suffered strokes. Physical therapists are recruited to work with these patients both in their own homes and in nursing and post-operative facilities.

Word of mouth

Several of the interviewed employers, mainly the human resource directors of nursing homes and assisted living facilities, indicated that they have not had to actively recruit health care employees at any level of skills for quite some time, because they get a lot of "word of mouth" referrals. One of the continuing care and retirement communities in Arizona, for example, is well known among foreign-born health care and social care workers as a "good place to work" and many migrant workers inquire about availability of positions. Similarly in Washington, DC, a human resources director at a retirement community in Northwest DC indicated that a relatively long history of hiring foreign-born nurses, mainly LPNs and CNAs, ensures a steady supply of workers when they need to hire new staff or need additional workers during vacation months.

Direct recruitment

Many large hospitals and health care organizations and systems recruit directly from abroad. Most specialize in particular countries. Below are two case examples of direct recruitment utilized by SouthWest Health in Phoenix, Arizona and Providence Hospital[58] in Baltimore, Maryland.

SouthWest Health is one of the largest, non-profit health care systems in the United States with 19 hospitals, six long-term care centers and an array of other services, including family clinics, home care services, a nursing registry and home medical equipment services in Alaska, Arizona, California, Colorado, Kansas, Nebraska, Nevada, and Wyoming. SouthWest Health employs nearly 22,000 employees, making it one of the country's largest employers. They began to recruit international nurses in 1999.

Arizona ranks 49th in the nation in the number of nurses per capita; the shortage of nurses is currently estimated to be 10,000. Their overall goal is to close the shortage in nurses and prepare for the future. SouthWest Health is building new hospitals to accommodate more patients but the average age of nurses currently employed in the hospital system is 47 years old. They want the diversity brought by international nurses. They have a recruiter on staff in the human resources office, but they also work with third-party recruiters. They recruit mainly from the Philippines, various parts of the Middle East, India, Africa, and the United Kingdom; the nurses recruited from the United Kingdom are mainly Indian. They do not recruit in South Africa because of the need there. They adhere to a self-imposed ethical recruitment approach.

The nurses they bring in must have at least two years of acute care experience. It costs them about $20,000 to bring in one nurse. Even when they recruit directly from abroad, they still hire a third-party sourcing agent to prepare the recruit, including helping them with signing up for the necessary examinations and with completing immigration paperwork. These costs correspond with the costs reported in the above-cited 2007 report on international nurse recruitment, which indicated that health care organizations pay third-party recruiters a standard fee of $15,000 to $25,000 per nurse depending on the state and the nurse's experience. The cost of $20,000 per nurse reported by SouthWest Health does not include the expenses related to additional on-the-job training they provide. A new U.S.-born graduate usually gets a base salary of about $50,000. The foreign-born nurses recruited directly from abroad receive comparable compensation, while the international nurses recruited by third-party recruiters

are placed on an expedited pay scale once they complete their two year contractual agreement with the recruitment agency to level them with natives.

The nurses are only brought in with immigrant visas (green cards); no H1-B visas are used. There is always a problem when a visa cap is reached which can also lead to unplanned retrogression, e.g., the time for processing admission is suddenly turned back. It took SouthWest Health 15 months to get their first international nurse in 1999. It takes 1.5 years just to complete the immigration process. Most nurses sign two-year contracts with SouthWest Health. After those two years they can look for different positions. However, more than 90 percent choose to stay with SouthWest Health.

Providence Hospital started recruiting aggressively in the late 1990s and early 2000s, mainly from the Philippines, when their vacancy rates in nursing hit the 13 percent mark. Their current Director of International Nursing Recruitment assumed her position in 2002. She is a Filipina herself and spent 12 years as director of nursing at a local hospital in Baltimore. She has both an interest and experience in geriatrics. She had been director of nursing at a hospital that also ran a nursing home with approximately 330 beds. She feels that the national debate on nurse shortages focuses too much on acute care at the cost of not planning for geriatric nursing.

Providence Hospital recruits directly from abroad, because the cost of going through a staffing agency is too high and the return – in terms of poor quality control and lack of understanding of the Filipino culture – is not worth the expense. Providence is in direct competition with other large hospitals in the area. They do work with one on-the-ground agency certified by the Filipino Department of Labor. The director of recruitment prefers this arrangement as it allows her to monitor the local recruiter more closely and helps to avoid unscrupulous recruiters. *Recruiters do not only exploit job applicants, they also take advantage of unsuspecting employers*, she said.

She conducts “mass interviews” in different sites in the Philippines. Usually, she advertises about three months ahead so the prospective applicants can

send in their resumes to the local Filipino recruiter. She posts eligibility criteria on the website; this helps to screen the applications. Providence considers foreign-born nurses for sponsorship only if they have the following:

1. CGFNS certification or United States RN licensure;
2. Minimum of three years current acute tertiary hospital experience prior to arrival in the United States to commence work. Tertiary hospital setting must have at least 150 bed capacity;
3. Good command of the English language. They require a score of 5.0 on the Test of Spoken English or the International English Language Testing System (IELTS), overall board score of 7.0, and speaking module score of 7.0. Providence interviewers complete face-to-face or phone interview assessments of the verbal English skill of each candidate. Applicants must be able to comprehend the questions and be able to express ideas clearly;
4. Are a graduate of an accredited nursing school with a proven track record;
5. Completed a Bachelor of Science in Nursing (exceptions are possible on a case-by-case basis);
6. Three letters of reference from immediate supervisors with a rating of "meet" or "exceed" job performance. This must come from a nursing supervisor, not physicians, unless a physician is considered the applicant's supervisor;
7. Medical and Surgical Skill or critical care checklist rated 3 or 4 on a scale of 1 (low) to 4 (high).

The application process takes about 1.5 years, from the filing of the I-140, through the visa process, to arriving in Baltimore. The application package must include the following elements:

1. Resume/CV;
2. Nursing diploma (or degree and transcript);
3. CGFNS certificate;
4. Foreign nursing licensure;
5. U.S. RN licensure (if available);
6. TOEFL and TSE scores or IELTS assessment;
7. Two professional references;
8. Nursing certification(s); and
9. Visa Screen certificate (if already obtained).

Usually, three people from the hospital go overseas, including a clinical nurse educator who is able to test the nurses' knowledge of certain procedures, to make final recruitment determination. The team recruits for three Baltimore-

based hospitals. Most nurses want to be placed at Providence, but the director of recruitment makes placement decisions based *on the match between the hospital culture and temperament and the personality of a particular hospital*. In the director's estimation *nurses from smaller, rural areas do better in smaller "more laid back" hospitals. After two years they can go on to Providence, which is a large hospital where everyone runs like chickens with their heads cut off.*

Most new recruits sign a two-year plus orientation contract directly with the hospital; orientation usually takes from two to three months. After the first contract expires, they can move to other hospitals. *Many go to California where there is a large Filipino community, but many stay,* said the recruitment director.

All nurses come in with green cards (permanent residency). The recruitment director advises them to come on their own for the first two to three months and settle in before they bring their family members. New graduates get $25.85 per hour which amounts to about $53,000 a year. Newly recruited nurses also get credit for years of experience in the home country.

Third-party recruitment agencies

Several hospitals in Arizona are using recruitment agencies to assist them in finding appropriate personnel. There are several recruitment agencies in the Baltimore-Washington metropolitan area; some of them work with local hospitals, while others recruit for hospitals located all over the country. Below are case examples of two third-party recruitment agencies: one based in Nogales, Arizona, which works mainly with hospitals in Arizona and the western United States, and one based in a Virginia suburb of Washington, DC, which covers a much wider geographic area.

The agency in Arizona provides experienced registered nurses as staff nurses to hospitals and health care employers in the western United States. They provide nurses for all clinical settings. Due to English language requirements they recruit only experienced nurses who are fluent in English. They also

provide assistance to foreign-educated nurses already in the United States who seek to adjust their immigration status. The president of the agency is a nurse herself; she received her M.S. in Nursing from the University of California in San Francisco.

They use an ethical recruitment model, focusing mainly on Filipino nurses. They pay the local recruiters based in the Philippines half of their finders' fee on hire and half on arrival. They work directly with the recruiters and use no other middle men. The president of the agency frequently visits the Philippines to oversee the recruitment process.

According to Philippine law, nurse recruitment agencies can recruit only 25 percent of nurses for export. The Philippines Overseas Employment Administration oversees recruitment and works to stop illegal recruitment practices.

The experience of the agency's president suggests that the best nurses are secondary migrants. She mostly recruits nurses that are eligible for immediate filing of the I-140 petition. This means nurses that have completed the CGFNS certificate or passed the NCLEX exam. Pass rate information based on nationality is available at ncsbn.org.

She can manage about 150 nurse applications at one time. The nurses that she brings in from abroad all come in as employment-based green card holders. The process for some of the nurses takes up to four years and requires a great deal of determination and patience; processing backlogs and retrogression account for some of the waiting time. To arrange interviews with hospitals she uses videoconferencing. She requests that the hospitals that use her services pay the nurses the same rate and provide the same benefits they provide to other members of the nursing staff; it creates loyalty and a more content workforce.

She tried to reach out to Mexico and recruit Mexican nurses, but was not successful. Many other programs tried as well and most failed due to language issues. We discuss recruitment from Mexico below.

The agency located in Virginia, right outside Washington, DC, was established in February 2001. In the beginning the current president of the agency was focusing strictly on nurse recruitment and was working with a few selected hospitals. Early on, he was able to recruit mainly Nigerian, Jamaican, Filipino, and Indian nurses; a few years later he started branching out to Singapore. Presently, they recruit in London, Dublin, and Glasgow but the nurses are from India, the Philippines, and a couple from Poland.

Currently, they are also recruiting physical therapists. Nurses are easier to place. Twenty five states (including Virginia and Maryland) participate in the Compact State Group which means that nursing licenses are portable between and among those states. When a nurse who passed her NCLEX in Maryland wants to relocate to Arizona, the agency is able to work with an immigration attorney on changing her I-140 and her exam and license are recognized there. The credentialing process for physical therapists is a bit more complex. There are a number of different credentialing bodies and different states require credentials from different credentialing institutions. The agency has to be very careful to make sure that the credentials match the particular state's requirements.

Although a foreign-born physical therapist might have passed the National Physical Therapy Exam, different states will require that that exam is verified by different credentialing bodies. For example, Maryland requires the Foreign Credentialing Commission on Physical Therapy (FCCPT), a non-profit organization created to assist the U.S. Citizenship and Immigration Services (USCIS) and U.S. jurisdiction licensing authorities by evaluating the credentials of foreign educated physical therapists (FEPTs) who wish to immigrate and/or work in the United States, to certify the credential, while Arizona wants a letter of eligibility from the Arizona State Board. Job portability is therefore much more limited. Nevertheless, the agency is moving into recruitment of physical therapists because it is the "next frontier," particularly in gerontology.

Over the past seven years, the agency placed about 200-plus international nurses, including 48 to 50 in just one Maryland hospital. The agency works

with both hospitals and nursing homes. The agency's website plays a role in recruiting nurses and physical therapists, but it is limited. The agency works with a freelance recruiter in Pennsylvania. One of the agency's administrative staff members is from the Philippines and he works with his own networks as well as training programs in the Philippines.

The nurses and physical therapists sign contracts directly with hospitals and nursing homes. The agency is paid a "head-hunter's fee" by the employers; the agency does not charge the workers any fees although sometimes they advance the nurses' airfare. Recently, the agency's lawyer advised them to sign contracts with each worker to spell out mutual obligations. The president told us: *We had one bad case of a Filipino nurse who lost her job and borrowed some money from us but did not want to pay back and tried to sue us. Only one bad case in the seven years we have been in operation.*

Nurses with green cards get the same pay as U.S.-born/educated nurses. Some hospital systems deal differently with credit for seniority. For example, *the Texas hospital system we work with*, said the agency president, *gives international nurses who had previously worked in US, UK and Canadian hospitals the same credit (and corresponding pay) for the number of years working as a nurse. However, nurses from India usually get 2.5 years of credit for every 5 years they worked as a nurse. The rationale is that some come from rural areas where the medical technology is not as advanced*.

The president feels that employers should pay attention to the region where the nurses come from, not just the country. He mentioned the Apollo hospitals in South India which are as sophisticated as many U.S. hospitals. His experience of working with nurses who worked in Saudi Arabia is that they have greater freedom in decision making than do U.S. nurses.

Our interviews in two major source countries of nurses – the Philippines and Jamaica – confirmed the increasing role that recruiters are playing. According to informants in Jamaica, what makes the recruiters so effective in bringing

registered nurses to U.S. institutions is that they make all the necessary arrangements: for immigration requirements of the candidate and family, for taking the appropriate qualifying examinations, for providing needed information about living conditions, and for logistical assistance in making the move. The immigration aspects are quickly addressed, but the entire process may take up to two years, depending on how long it takes for the new recruits to pass their exams and prepare their families.[59]

The Philippines Overseas Employment Agency lists nearly 3,400 approved recruitment agencies in its records.[60] Any individual who wishes to establish a recruitment agency must apply for a license with the POEA. The following basic requirements must be met:

- At least 75 percent of the authorized capital stock is owned and controlled by Filipino citizens.
- A minimum capitalization of Two Million Pesos (P 2,000,000.00) in case of a single proprietorship or partnership and a minimum paid-up capital of Two Million Pesos (P 2,000,000.00) in case of a corporation must be available.
- Individual owners must not have nor ever had a criminal case filed with the National Bureau of Investigation, or a record with the Anti-Illegal Recruitment branch of the POEA.
- Individual owners must not be affiliated with the POEA, Overseas Workers Welfare Association, Department of Labor and Employment, or any travel agency due to possible conflict of interest.
- Licenses must be renewed every four years, meeting the same requirements as above.

Very little is provided in the guidelines about job standards, ethical recruitment, or skills matching. Regulations are heavily business-oriented, and they deal mostly with revenue requirements. [61]

Recruitment is supported by the about 350 private training institutions that teach to the standards required for passing the U.S. examinations. These institutes are of varying quality. A 2005 study by the Commission on Higher Education found that in 57 percent of the training institutes, less than 50 percent of the students were able to pass their examinations.[62] Some of these institutes

had shifted from teaching Information Technology after the 2003 dot.com bust to what was seen as a more economically advantageous sector. Students were willing to pay large amounts to be trained in an occupation that appeared to be in growing demand in the United States and other destination countries. Reportedly, the lure of immigration possibilities even drew some physicians to retrain for nursing in the hopes of easier admission to destination countries.[63]

SUPPLY AND RECRUITMENT OF MIGRANTS IN DIRECT CARE

Direct care workers are distinct from professional care workers in many ways. Direct care workers tend to find their way into eldercare in quite different ways from professionals, both in terms of their occupational and immigration pathways. They tend to have less education, training, or certification requirements; and they tend to come to the job by routes other than health care or training specific to eldercare. There are no visas that favor their admission in the immigration system. We interviewed 15 direct care workers, representing the countries of Ethiopia, Eritrea, Sierra Leone, Russia, Mongolia, Cameroon, and Bolivia, individually and in group settings, as well as several recruiters and employers in Arizona and the Washington-Baltimore area.

Migrant workers' routes into care in the United States

Unlike most of the nurses interviewed for this project that came to the United States having been recruited overseas for specific jobs and indicated economic reasons as the main impetus for migrating, none of the care workers arrived in the United States to assume employment in the adult care sector. Some came as refugees, mainly from Ethiopia, Eritrea, Sierra Leone, and the former Soviet Union. Others came as immigrants to reunify with family members already in the United States.

Becky, for example, joined her husband who was a Colonel in Ethiopia; it is unclear whether he came as a refugee or with some other immigration status.

However, Becky and her children were admitted to the United States under a family reunification mechanism. At first Becky did not intend to work outside the home, but when her children got older and started going to school she decided that she wanted to pursue training in nursing. A friend told her to look for a job at a retirement home that provided tuition assistance to personal care managers who wanted to become certified nurse's assistants or licensed practical nurses.

Several Russian women accompanied their husbands who came to the United States on J-Visas as researchers. Nina arrived with her husband in 1988 from St. Petersburg. He is a scientist and came to the United States on a J-Visa to work with a research team at the University of Maryland at College Park. Later, he switched to an H-1 visa and now the family is in the process of getting their permanent residency (green cards). Nina complained that it was always a long and slow process to adjust to a new immigration status.

A Mongolian woman, currently working in a retirement home in Virginia, won a green card lottery. The U.S. government issues 55,000 green cards every year through the Diversity Immigrant Visa Program, commonly known as the Green Card Lottery. Applicants are selected randomly by a computer generated drawing. If selected, the main applicant, spouse, and all unmarried children younger than 21 years of age have a chance to apply for permanent resident status in the United States. Ely said: *I must have sent in hundreds and hundreds of applications. I tried three times and the last time it worked. I am thrilled to be here. I think I can make a good life in this country for myself and for my family.*

The pathway to employment in the adult care sector in Arizona is quite interesting. Arizona allows relatives who care for their elderly parents and other relatives to be compensated for these services. Many caregivers take on additional patients to supplement their families' income. In fact, some entrepreneurial immigrants turned this opportunity into thriving businesses. Two foreign-born nurses from Russia took advantage of this provision and started businesses recruiting social care workers to provide in-home care and work at

an adult day care center, respectively. They have also recognized that there is a growing foreign-born elderly population in the state and have taken a multicultural approach to service provision; they have tapped into the existing immigrant communities to recruit workers to provide services in Spanish, Russian, and English.

Betty started her in-home care service business four years ago. She took care of her own elderly father and recognized the need for in-home care workers among both U.S.-born and foreign-born elderly. It took about 16 months for the company to make a profit, but once things took off, *they really took off*, she said. She currently employs 70 direct care workers, most are foreign born. Their job retention is good; 35-40 care workers have been working for her for two years or longer. They range in age between 29 and 60 years old and are all state qualified. All have been fingerprinted and CPR certified. She pays very close attention to the certification process and to the legal immigration status of potential employees because 70 percent of her business comes from direct referrals from the state; the rest comes from word of mouth. Betty is not only the owner of the in-home care business but also one of its employees. She likes this line of work and does not want to spend all of her time in the office. However, at the rate the business is growing she may have to devote all of her time to management tasks soon. Her husband is also an employee of her company.

Zoya has lived in the United States since 1991. She was trained as a nurse in Russia. She came with her parents from Russia and originally settled in New York City. She worked in assisted living facilities in Queens and in Brooklyn for several years and wanted to use these experiences to start a similar business in Phoenix, Arizona. She moved to Arizona because she likes the warm weather. After researching elder care facilities, speaking with groups of elderly residents as well as with health care administrators catering to older clients, it became evident that what Phoenix needed was adult day care centers. She decided to open one. Zoya says: *We have a niche with the Russian* [elderly] *population, which along with the overall population in the Phoenix metro area is growing. There are many secondary Russian migrants to Phoenix and overall Phoenix*

gets 10,000 new residents on a monthly basis. At the time of our research, Zoya employed six staff members to work at the adult day care. All six are foreign born and have backgrounds in nursing. Her goal is to have about 45 clients. She feels that serving 45 clients would both bring in sufficient profit and be manageable.

The metropolitan Washington area is home to many immigrants and refugees, some of whom are getting old and require in-home care. One agency employs a part-time Vietnamese staff member to recruit Vietnamese-speaking in-home care workers to serve elderly Vietnamese in Northern Virginia. Mr. Nguyen[64] told us that at the height of the Vietnamese refugee resettlement in the 1980s most Vietnamese elderly in the area were taken care of by their family members, mainly adult daughters as well as female members of the extended family. *Today*, he said, *most adult children of the Vietnamese elderly work outside the home or moved to different states and localities, so the older Vietnamese are in the same situation as all other elderly. They need to rely on hired help.*

The majority of migrant direct care workers we interviewed in the Washington metropolitan area work in Continuing Care Retirement Communities (CCRCs), sometimes called life care communities. Entering one is usually a once-in-a-lifetime choice and that is the appeal for many older Americans. Many have large campuses that include separate housing for those who live very independently, assisted living facilities that offer more support, and nursing homes for those needing skilled nursing care. With all on the same grounds, people who are relatively active, as well as those who have serious physical and mental disabilities, all live nearby. Residents then move from one housing choice to another as their needs change. While usually very expensive, many guarantee lifetime shelter and care with long-term contracts that detail the housing and care obligations of the CCRC as well as its costs.

One of the Northern Virginia retirement communities we studied is part of the Sunrise Senior Living network, which was established in 1981and operates

more than 440 senior living communities throughout the United States, Canada, the United Kingdom, and Germany with a combined resident capacity of more than 52,000. Sunrise employs more than 38,000 team members serving seniors. There are 15 Sunrise communities in Virginia and three in Washington, DC. The Northern Virginia community employs 130 to 140 staff members; 70 of them are personal care managers (social care workers). The executive director of the facility estimates that about 65 to 70 percent of their personal care managers are foreign-born; the rest are African-Americans. One of the "neighborhoods," as the different parts of the retirement community are called, we had a chance to observe in the course of this research employs 40 personal care managers; 32 are foreign-born and eight are African-American. Participant observation of this particular neighborhood and interviews with its coordinator and nine of its foreign-born and three African-American personal care managers revealed that the majority of the migrant workers treat their jobs as a stepping stone to a nursing degree. The facility offers tuition assistance and several of the migrant workers are either already taking advantage of this benefit or plan to do so. One of the Cameroonian women is enrolled in a nursing training program at a local community college and receives $1000 per semester in tuition assistance.

Virtually all of the interviewed workers stated that they felt prepared for work with elderly residents because they had experience caring for older relatives in their home countries. Some were motivated to enter this profession by their religious beliefs. A Coptic Christian Ethiopian woman said: *The Bible teaches us to respect and care for our elders. I feel I am fulfilling my duty as a Christian when I work here.* Others liked the shift work which allowed them the flexibility needed to care for their own families and/or pursue educational goals. Shift work, including night and weekend shifts, allowed for working more than 40 hours a week and earning more money. Azalech and Alem liked being "on call" outside their weekly schedules; in fact, they had to reschedule their interviews with the research team twice because they were called to fill in for an absent co-worker or to provide extra help when there was a crisis in their neighborhood.

As we saw in Arizona, there were also several entrepreneurs among the in-home care workers we interviewed in the metro DC area. Incidentally, all three of them were also from Russia. Vera, an engineer by training, is a good case example of these self-employed in-home care workers. Despite her background in civil engineering, Vera could not find work when she and her husband first came to the United States. Her husband was making good money so she stayed home taking care of their son, but when her son went to college she started to look for work again. An acquaintance of hers remarked that she is a very compassionate listener and should work with home-bound elderly. She researched this possibility and decided that indeed this was something she wanted to do.

She proudly said: *I am a business woman, I am self-employed and my own boss.* Vera started her business in 1998, ten years after she arrived in the United States. In the intervening years she has worked with several personal care agencies that refer elderly clients to her. Currently, she is working with two agencies: Montgomery County Personal Care, a public program, and Circle of Friends, a private agency. She cares for three elderly women; all Russian-speaking. Vera said she used to care for non-Russian speaking clients, but did not think she was emotionally as helpful to them as she can be to Russian-speaking clients. She said: *Anyone can bathe people, make their bed, and feed them, but it is the psychological dimension that is most important… You cannot be a good psychologist in a foreign language.* Although Vera's English is quite good she would slip into Russian while discussing the psychological needs of her clients. She said: *The elderly people want to reminisce about their past, about the books they read when they were younger, about life when they were growing up and I did not grow up in this country, I cannot understand their memories… but with my Russian clients, we have so much in common! I can soothe them reading poetry in Russian and singing songs they mothers sang to them. It's very different; much more meaningful, both to them and to me.*

Recruitment agencies do not play a significant role in recruiting social care workers in Arizona or in the metro DC area. The only care workers that worked with recruitment agencies were the self-employed entrepreneurs. While some agencies recruit for retirement communities or hospices, they mainly supply

these facilities with nurses (at all levels of skill), not social care workers. Most social care workers find jobs through informal networks. Stacy, a coordinator at one of the retirement communities in Northern Virginia, said: *Most people learn about vacancies through word of mouth. I never have to place ads in the paper. I look mainly for a good heart, good communication skills, and a cheerful personality*. The same can be said about the continuing care and retirement community we studied in Arizona. They have not had to actively recruit new care workers for quite some time, because they get a lot of word of mouth referrals. Their employees hail from 29 different countries and talk to their family and friends about openings on campus.

Reasons for employing migrant care workers

Interestingly, labor force shortages are not the main reasons for hiring foreign-born care workers. Without exception, all employers interviewed for this project listed personality traits (caring, cheerful, hard working, etc.) and attitudes towards older people (ability to be patient when working with older individuals, experience carrying for older relatives, etc.) as the main reasons for hiring immigrant workers. The cultural differences in approaches to older adult care were considered an asset not a hindrance. Employers mostly emphasized the fact that foreign-born care workers were more interested in the elderly and more attached to them than U.S.-born workers. Overall, employers felt that immigrants make better employees. They have a strong work ethic and are loyal both to the place of employment as well as to the elderly in their care. Of course, statements about immigrants' strong "work ethic" may be code for a willingness to work longer hours and accept lower wages. However, our findings are that the foreign born in long-term care occupations do not work longer hours and actually earn more than their native counterparts.

Challenges of employing migrant care workers

In contrast to foreign-born nurses where differences in educational backgrounds and communication styles did pose some challenges and required additional

on-the-job training, employers were less concerned with migrant care workers. It is difficult to determine whether this lack of concern stemmed from the fact that hiring care workers did not involve as much investment – financial and otherwise – as hiring foreign-born nurses or whether care workers did indeed pose fewer challenges.

English language abilities as well as a strong accent in English seemed to have been the main challenges. Both employers and migrant care workers emphasized that some older people, particularly those hard of hearing, have had difficulties understanding accented English. On the other hand, a human resources director in one of the retirement communities in Washington, DC that caters to many retired foreign service officials said: *Our residents love to chat with our foreign-born workers. They like to dust off their French or some other foreign language and speak it with the nurses or the maintenance staff. Some of them speak really exotic languages that I do not recognize.*

Impact on staff relations

Given the very diverse workforce in all of the organizations and facilities we studied, many people were surprised that we were even inquiring about the impact of migrant care workers on staff relationships. A group of diverse staff members, including migrant and U.S.-born minority care workers, told us: *There is no union in this facility, all we have is each other.* A supervisor in the same facility remarked: *When we hire a new care worker who represents a new ethnic group, it takes a few days to get used to a new accent and a new culture, but I do not recall ever having any problems with my staff because of animosities between migrant and native workers.* She added: *I am Caucasian, but my children are biracial and the migrant workers love to see pictures of them displayed in my office. It's a nice icebreaker when I am interviewing minority workers.*

The research team interviewed several African-American care workers who work side-by-side with migrant care workers; they had nothing but positives to say

about "the internationals." One African-American woman told us: *I had no idea how hard life was in many places in Africa until I started talking to my co-workers from Sierra Leone or Ethiopia.*

Relations with employers and working conditions

For the most part both employers and migrant care workers reported very good working relationships. A supervisor at a nursing home said: *The foreign-born workers are easy to work with; they have a very positive outlook and are very much liked by the residents.* Interestingly, the self-employed in-home care workers mentioned that they preferred to work for themselves than for someone else. One or two of the interviewed women indicated that demanding and unreasonable supervisors were the reason they started to freelance or opened their own business. . One home health aide said: *My old supervisor* [in a nursing home] *constantly told me not to do too much for the residents. They will take advantage of you,* she said, *and that's why I quit and went to work as a home health care so I do not have someone telling me how to relate to the people I care for.*

Most of the interviewed migrant care workers work 40 hours per week or more. Care workers in assisted living and retirement communities work three shifts: 7 am to 3 pm, 3 pm to 11 pm, and 11 pm to 7 am. Because of the shift work they can work overtime. The starting wage in assisted living facilities is $9.50/hr and the maximum wage is $11.50/hr. They also receive health (including dental) and retirement benefits.

The most difficult aspect of the work according to the interviewed care workers is taking care of older men who do not always behave appropriately. The research team was able to observe mini-training on how to behave and what to say when a resident asks for assistance which makes the personal care manager uncomfortable. The trainer/supervisor was very open about male residents who often take advantage of shy young care workers and how discussed how to deal with them; she went as far as having the care worker role play and practice appropriate responses. The second most difficult task mentioned was

lifting residents; all the care workers found it physically demanding. When asked why they chose this line of work they responded once again that they had experience caring, typically for their grandparents, and felt prepared to take on jobs in nursing facilities. As discussed earlier, one Ethiopian woman also invoked her religious beliefs as an impetus for taking the job.

In-home care workers command similar wages to the wages offered by retirement facilities and nursing homes. Vera, a self-employed home care aide, made about $10/hr when she first started in this business in 1998. Currently, she makes $12/hr working with clients referred to her by the Montgomery County Personal care agency and $9.75/hr working with clients referred by a private agency. She said: *You do not get rich in this job, but I like the flexibility and it suits me.* Vera works close to 40 hours a week, sometimes more. A few months ago, one of her clients was very ill and she then worked with her every day for several hours. Otherwise she mostly works with clients two to three times a week for a few hours each day. She said she likes her job and gets a lot of satisfaction from it. In all of the 20 years in this line of work, she had one very demanding – borderline abusive – client and she had to drop him. She hopes to continue this work for the foreseeable future. She likes the independence the job gives her. She gets health benefits through her husband's job. She does not have paid vacations, although she was taking a week off and leaving for vacation in South Carolina (to visit her son) and Florida (to visit a friend) a day after our interview.

EMPLOYERS' DEMAND FOR MIGRANT CARE WORKERS

We undertook a large, online survey of employers in nursing homes, as well as in the delivery of home care services. We benefited from the responses of members from two major organizations that responded to invitations and advertisements – primarily the National Association for Home Care and Hospice (NAHCH), and the American Association of Homes and Services for the Aging (AAHSA). The sample included 788 respondents of whom 470 were employers

in nursing homes or assisted residential care facilities, and 318 were employers in home care placement companies. The web survey presented respondents with a series of questions about their demand for and experience with immigrant workers. In the following section, we complement the online survey with relevant descriptions from our fieldwork that shed more insight on these issues.

Difficulties in recruiting or retaining U.S.-born workers

To begin with, we asked why it was "difficult to recruit or hire U.S.-born workers." Figure 2 shows that 67 percent of respondents indicated a "general shortage of native workers" with the "right skills." However, additional reasons suggest the shortage of native workers is also not simply a question of the right skills: 60 percent indicated difficulties hiring U.S.-born workers because they can "earn more" at other jobs, and 53 percent said that natives "demand higher wages and benefits." Given this sentiment, it is not surprising that about half of all employers also stated that "turnover" of natives was very high and that natives were not "willing to work nights and shift work."[65] The questionnaire allowed for open-ended, written responses and these give a greater sense of employers' perceptions.

> *I think most Americans are not interested in working in nursing facilities due to traditionally low pay, minimal benefits and virtually no opportunities for advancement* (Nursing Home, Suburban, Georgia).

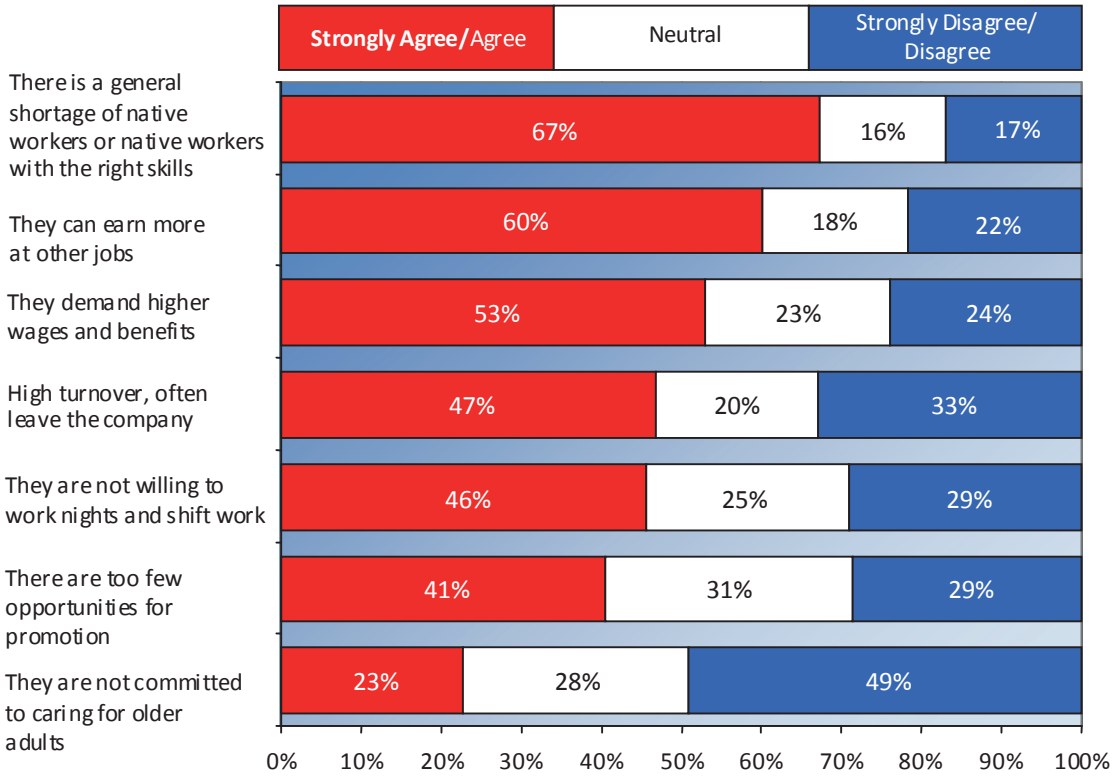
> *There is a general bias in the U.S. against working in nursing homes. U.S. women in particular have more options for work that are family friendly (no weekends, no nights, more flexible hours) than the nursing profession offers* (Nursing Home, Urban, Massachusetts).

> *There simply are not enough nurses in our area! We have two medical schools with teaching hospitals and two other large hospitals within a 20 mile radius, not to mention numerous other long-term care facilities, outpatient clinics, dialysis centers, etc.* (Nursing Home, Urban, North Carolina)

> *It is very competitive with wages for nurses right now. I also feel that the new nurses coming out of nursing school feel that they do not want to pay their dues by working different shifts.* (Nursing Home, Suburban, Massachusetts).

Our facility is in a suburban area where American-born young people won't do this type of work and older American-born workers tend to be well educated beyond our needs and ability to pay (Nursing Home, Urban, Minnesota).

Figure 2: U.S.-born workers are difficult to recruit/hire at your site because (n=390):



It is evident that a large majority of employers perceive a shortage of U.S.-born workers, reporting that the shortages are associated with wages and working conditions, as well as competition from hospitals and other providers. They also suggest generational factors and even the litigious nature of U.S. society and the pressures that possible law suits place on nurses. But while the question itself does not make a difference between nurses and direct care workers, the written responses single out nurses, leaving an impression that shortages of lower-skilled, direct care workers may not be as acute.

Difficulties in recruiting professional caregivers: fieldwork findings

Virtually every employer we interviewed both in Arizona and in the Baltimore-Washington metropolitan area mentioned nursing staff shortages. According to one nursing educator, *Arizona has a critical shortage of nurses and nursing educators continue to identify innovative ways to resolve this crisis. Arizona ranks 45th in the U.S. related to the nursing shortage with 626 RNs per 100,000 compared to the nation with 782 RNs per 100,000 persons. In addition, Arizona's population is growing and becoming more diverse*. A recruiter at SouthWest Health in Arizona said that *there is a shortage of about 10,000 nurses in the state which ranks 49th in the country in nurses per capita.*

The president of a recruitment agency in Arizona provided a very lengthy explanation of the existing shortage of nurses. She explained, *There is a concept of "Hours of Care per Patient Day (HPPD)" in Arizona. Many nurse executives and managers budget the number of nurses needed by calculating the total direct productive HPPD for the number of patients expected to require nursing care over a given time period. Calculating the HPPD takes into account the time nursing staff directly interacts with patients (i.e., the time it takes to administer treatments and medications, and monitor patients). It also reflects the time staff takes to document care, order supplies, prepare medication, and direct other caregivers. HPPD equals the sum of all direct care time provided by all staff members (RNs and ancillary staff) who care for one patient in a 24-hour period. Actual HPPD may differ from the budgeted HPPD for several reasons. For example, if staffing vacancies exist because they cannot be filled as a result of staff illness or a shortage of staff to hire, then the actual HPPD would be lower than budgeted. On the other hand, actual HPPD would be higher than budgeted if patient acuity was so high that extra nurses were called in to provide care or if an RN was not available and had to be replaced by two nursing assistants.*

Most executives in Arizona hospitals budget about seven hours of care per patient day. The margins are very tight and hospitals often end up asking nurses to stay late to cover the need to provide care. This can cause a lot of stress on

the nursing staff. The University Medical Center in Tucson has taken the opposite approach; they have resorted to closing beds so they don't stress their nursing staff. So there is a shortage of nurses in Arizona and hospitals are reluctant to stretch their staff too far. To maintain this there is a mandatory nurse/patient ratio. At UMC in Tucson the nurse to patient ratio is 4/1. Nursing shortages cause significant wait time in some instances. She mentioned waits up to 14 hours in some local hospitals. She added: *This shortage, coupled with rapid population growth in both the Tucson and Phoenix areas has led hospitals to use nurse staffing agencies to meet their need for nurses.*

Difficulties in recruiting direct caregivers: fieldwork findings

The supply and the demand for migrant in-home care workers seem quite different in Washington, DC. While the metropolitan Washington DC area is home to many refugees, immigrants, and undocumented migrants who are always looking for ways to improve their economic situation, the District of Columbia also has its share of low-income U.S.-born residents looking for similar economic opportunities. Interviews with recruiters at a private, non-profit home care agency that provides a wide range of supportive services for elderly, chronically ill, and disabled residents, indicate that the proportion of foreign-born home care aids among their 200-plus employees is very small. In the past year they hired only three or four migrant home care aids, mainly Ethiopians.

Most of their home care aides are African-American females in their early 20s, graduates of the Life Pathways program called Empowerment for Success (EFS). The EFS program prepares participants for entry into a training program leading to a national certification as home health aids. The 12-day training program is conducted by licensed social workers and registered nurses with support from field counselors. The program includes a mixture of lectures, discussion, audio-visual and hands-on demonstrations in an on-site training lab. Two days of supervised "on-the-job" internships in the homes of clients are an essential part of this training. The program culminates with each student's demonstration before an RN of the skills they have learned and a proctored, national exam. Students who successfully master the required skills and pass the exam obtain

nationally recognized certifications as Home Care Aides. The graduates of this training serve mainly middle-class Caucasian clients who can afford to pay for these services out-of-pocket or who have long-term health care insurance that covers these services.

As indicated above, Washington, DC-based recruiters working with in-home care workers seem to think that it is fairly easy to find U.S.-born workers among welfare dependent young women. These recruiters work with different welfare-to-work programs to train program participants to provide in-home services to the aged and homebound individuals. They indicate that the small numbers of foreign-born they work with are "walk-ins." Recruiters in the District of Columbia do not target immigrants, but they also do not turn immigrants away if they wish to be trained as home health aides or personal care aides. However, the situation is quite different in the suburbs. Employers, in particular, seem to think that there is a shortage of U.S.-born workers at all skill levels. One human resource manager put it as follows: *The older generation of personal care aides who used to work in our retirement and nursing homes is reaching a retirement age. Younger people go to college and do not want to do this kind of work anymore. If they go into elder care then they usually have some sort of a nursing training and are overqualified for personal care aide positions. Anyway, with professionalization of elder care in different facilities come higher expectations regarding qualifications of workers. For this retirement home* [a continuing care retirement community in Washington, DC.] *I hire mainly nurses at all levels of skill. The only people without nursing credentials we hire are maintenance and landscaping staff. Virtually all of them are immigrants. Our cafeteria staff is also composed of mainly foreign-born workers, but they are hired by the catering company we use.*

Problems with immigration regulations and use of recruiters

Yet, despite apparent shortages of domestic workers, only a simple majority of employers report having "ever hired an immigrant," 53 percent in nursing homes and 40 percent of those in home care. After all, immigrants remain a distinct minority of the workforce. Indeed, as table 5 shows – for those employers who

report ever having hired an immigrant – most foreign-born workers are a small percentage of all workers.[66] In about 75 percent of workplaces, foreign-born nurses and specialized workers[67]are less than 5 percent of employees; and in 52 percent of workplaces foreign-born lower-skilled workers are also less than 5 percent of employees.[68] We can roughly estimate that the foreign born are 9 percent of nurses, 11 percent of specialized workers, and 17 percent of lower-skilled workers. These approximate estimates show a greater share of immigrants among direct care workers and they are in the same "ballpark," albeit somewhat smaller, than the percentages we estimate elsewhere based on random, national data.

Table 6: Foreign-born percentage of total workforce by occupation

Percent of workforce	Registered nurses		Specialized workers		Lower-skilled workers	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
1 to 5 %	229	78%	212	74%	140	52%
6 to 10 %	17	6%	30	10%	37	14%
11 to 15 %	8	3%	9	3%	14	5%
16 to 24 %	7	2%	13	5%	16	6%
25 to 49 %	14	5%	8	3%	27	10%
Over 50 %	17	6%	15	5%	35	13%
Total	292	100%	287	100%	269	100%

Source: Online survey of employers.

Recruitment agencies and employment contractors are not widely used by providers in this survey. About 90 percent of home care agencies and about 80 percent of nursing homes/long-term care providers reported that they did not use recruiters or contractors. Written comments suggest that access to immigrants when natives are unavailable permitted them to use their own employees, rather than use temporary employment agencies. The feeling appears to be that the overall care and satisfaction of their elderly residents and families is higher when they used their own staff. This sentiment may be, in part, why contractors in particular are so little used. As one respondent wrote, access to immigrants … *has improved the quality of our care because we are not forced to use agency personnel* (Nursing Home, Urban, North Carolina).

Yet, when recruiters are used it appears that they may be primarily used to hire immigrants, in particular professional care workers. As figure 3 shows, when we asked the few employers who report using recruiters or contractors why they did so, immigration regulations were the leading reason reported – 80 percent report that recruiters are valuable in helping with "the immigration paperwork," while 53 percent report the same reason for using employment agencies. When they looked to fill their staffing needs with immigrants they were overwhelmed by the process. It became clear from written responses that recruiters were used to directly hire immigrant nurses:

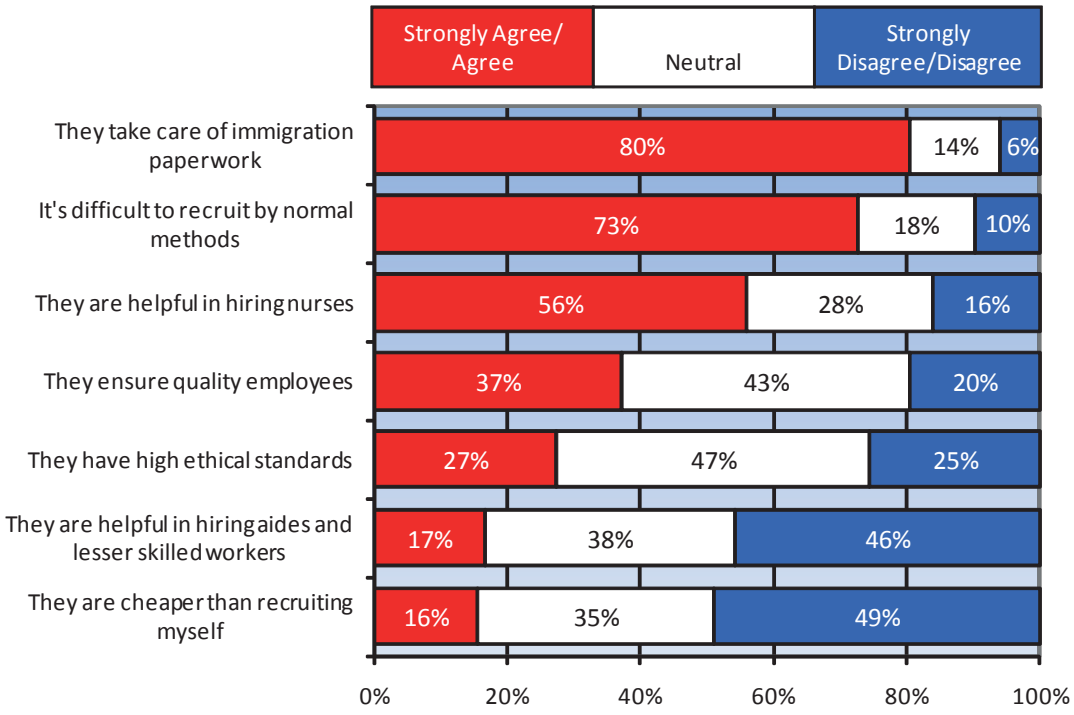
> *[There is] constant regulatory change and uncertainty about these changes and the timing of availability for future additional work visas for foreign trained health professionals* (Nursing Home, Urban, North Carolina).
>
> *General experience has been good, as the agency I use knows and understands the immigration laws and difficulties. They know when and how to apply for visas and licenses* (Nursing Home, Rural, Nebraska).
>
> *An antiquated and outdated system prevents the employment of incredibly qualified nurses (in the case of the Philippines) despite the fact that there are not United States citizens available for the positions available* (Nursing Home, Rural, Wisconsin).

Part and parcel of the use of recruiters may be to access immigrant workers because, as 70 percent report, it is "difficult finding workers through traditional channels." Similarly, part and parcel of the use of contractors may be, as 50 percent of employers report, that a contracted worker "is easier to let go" or fire. While recruitment agencies and contractors help fill staffing needs, they are expensive and the quality of employee varies. Thus, recruiters and contractors are not a first resort; and employers were clear that recruiters are most often used to hire nurses rather than lower-skilled workers.

At the same time, in another question we asked respondents if they find "government regulations" on immigrant workers to be "problematic." Recall that most employers report that they have not hired immigrants, so only about one-third of the sample answered our set of questions about regulations. But of these employers, more than 75 percent reported that their biggest problem

with immigrant regulations was that they are "uncertain" about the legal status of immigrant workers. About 70 percent report that it is time consuming to fill out the "hiring paperwork." And 70 percent report that they have additional "uncertainty" about the law's requirements, which must compound the concerns of the 60 percent who report anxieties about possible penalties for "hiring unauthorized workers."[69] While employers are uncomfortable hiring low-skilled immigrant workers, it seems that they have little recourse. Yet, they still tend not to turn to recruiters or contractors.

Figure 3: Recruitment agencies are beneficial for your site because (n=51):

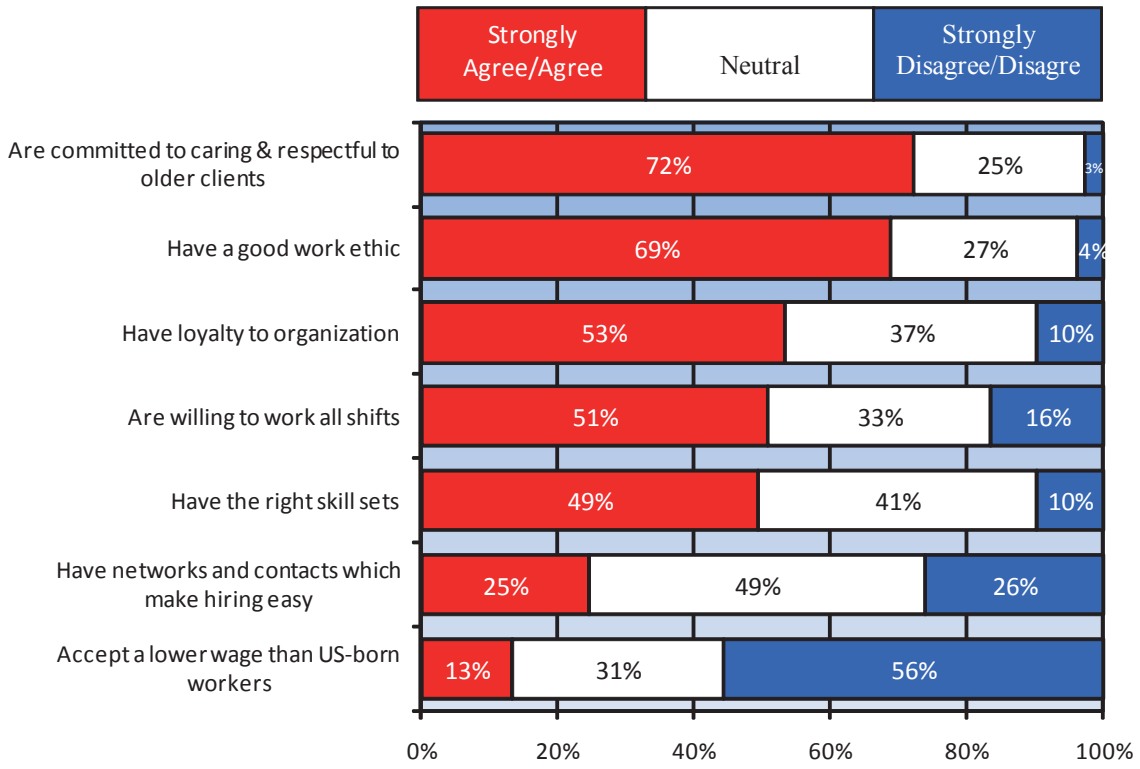


Advantages of employing migrant care workers

There is a strong and generally favorable view of the "advantageous" work habits of the foreign born. Figure 4 shows that 72 percent report that immigrants are "committed, caring, and respectful" of clients, 69 percent that they have a "good work ethic," and 53 percent that they are "loyal to the organization."

Immigrants are highly lauded for the care they take of elderly clients. Respondents attributed immigrants' care and commitment to a cultural emphasis on caring for the elderly.

Figure 4: Immigrant workers are ADVANTAGEOUS at your site because they (n=318):



Immigrant workers can be very committed to quality health care and compassionate to the elderly. This is because in many of their home countries the elderly are valued…more so than the USA. (Nursing Home, Urban, State Not Mentioned)

Because of the traditional belief that children take care of their elderly emotionally and financially and continuing generations of family take care of each other, nurture and support each other, Filipino caregivers stand out as far as elderly care is concerned. (Home Care, Rural, New York)

My primary experience has been with Filipino nurses and aides…they were the most loyal and dedicated employees I have had (Nursing Home, Rural, Virginia).

While employers clearly perceive that immigrants have excellent work habits which most attribute to their cultural outlook, a few note that the marketplace and immigration process contribute to their "availability" and "loyalty."

> *They vary in their abilities just like Americans – some excellent and well-educated and caring – some not* (Home Care, Urban, California).

> *Foreign-born workers are available. You cannot find U.S. workers. If an agency sponsors an immigrant worker, they are bonded to work a certain number of years – so you have their employment for a set time, unlike U.S. workers who job hop* (Home Care, Suburban, No State Provided).

> *Many of our caregivers arrived to the country at middle age (40-50 years of age and older) and their age and lack of advanced English prevents them from pursuing other careers. Therefore, these people are very loyal to our organization… and remain in their positions for a long time* (Home Care, Suburban, Maryland).

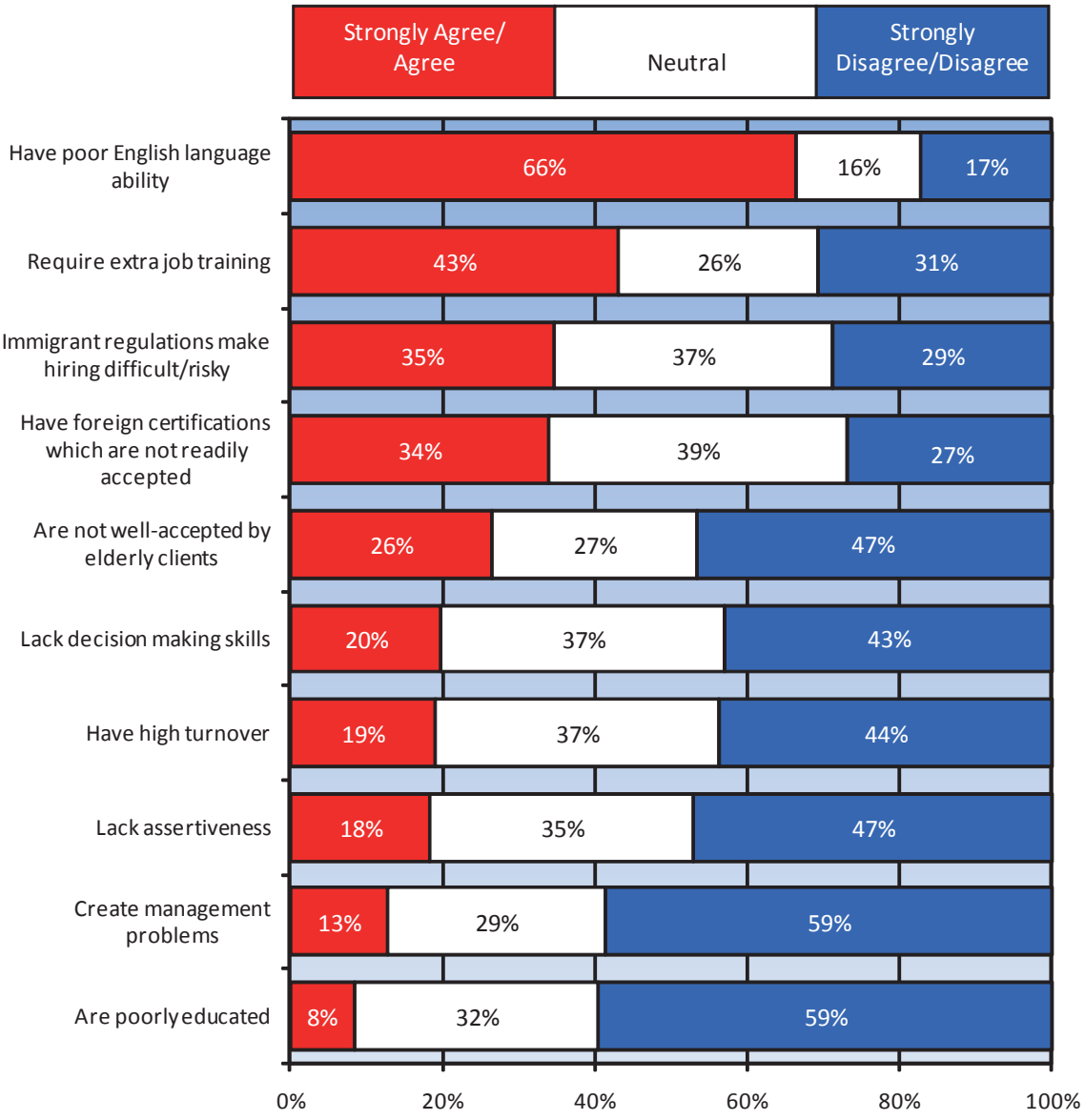
About half of all respondents said that immigrants were additionally advantageous because they are willing to "work all shifts" and have the "right skill sets." Employers would, naturally, value workers willing to work night shifts and weekends, etc., especially given the widely recognized difficulty of retaining workers on shift work. As for the general question on skill sets, respondents written comments distinguished formal medical training from cultural or language ability. The latter skill was particularly coveted when the nursing home or home care company provided care to aging immigrant populations. At the same time, immigrants are not seen as advantageous because they are willing to "accept lower wages" – most employers, 55 percent, report strongly disagreeing with any such assessment. Immigrants' advantages appear to be loyalty, willingness to work odd shifts, and the value that they place on assisting the elderly.

Issues in providing care

Of course, immigrants also present some unique challenges. As figure 5 shows, most employers, fully 66 percent, indicate that "poor English ability" is the biggest challenge. Communication issues, both knowledge of the language and speaking ability/accent, are at the root of client perceptions of poor care. And English skills are critical because of the steep learning curve many immigrants

face. New foreign-born nurses must learn new technology, new assessment methods, and deal with the stresses of a litigious society in addition to the normal anxieties of moving and adapting to a new country.

Figure 5: Immigrant workers are CHALLENGING at your site because they (n=333):



> *Limited English knowledge and heavy accents make communication with elderly clients with hearing deficiency complicated. Strong accents can make teaching difficult with elder, hearing impaired patients* (Home Care, Suburban, Maryland).

> *The language problem limits where I can place aides without the same language. I find that older people in our area shy away from people with darker skin and people who don't speak the same language* (Home Care, Rural, North Carolina).

Indeed, 43 percent of employers report that immigrants often require "extra job training," if not always for their formal skills, then to improve their English. While a large majority of employers felt that the education of the foreign born was adequate (not poor), they require extra training for their positions.

> *They are not poorly educated; they just have a language problem. When properly trained in their position they are assertive and perform wonderfully. The extra dollars spent in training will make you more on the back end – training and education will always pay off* (Nursing Home, Rural, Tennessee).

Roughly one-third of the respondents indicated that "immigration regulations" governing the employment of immigrants make "hiring difficult or risky." This echoes the answers above on why employers use recruiters and, again, their written comments made it clear that their greatest concern was with the regulations on legal, nursing immigration. They expressed dismay over long processing backlogs and wait times of up to 4 years. Others complain about the processing costs which have "tripled" over the past several years, making the process more expensive for applicants and jeopardizing the ability of foreign health care workers to come with their families. Also, the professional certification process for foreign health care workers is perplexing to some employers.

> *If there is a vacancy and you use a company to recruit a worker from a foreign land, it could take two years to bring that person over – an unacceptable length of time* (Home Care, Suburban, Tennessee).

> *We had hired a foreign nurse who took and passed the New York Nursing Boards for Registered Professional Nurse, and did not know she was ineligible for RN licensure until several weeks passed and she did not receive her license… she needed a CGFNS document… a Diploma is not enough. She resigned and eight months later still does not have her license* (Nursing Home, Rural, New York).[70]

Although apparently not widespread, tensions among different immigrant groups, often from the same country, can also create challenges. And inappropriate behavior among foreign-born workers can exacerbate any mistrust or uneasiness that native-born clients have towards foreign-born caregivers. While we did not conduct interviews with elderly clients, our research suggests that some may be uncomfortable with an immigrant's race, ethnicity, or lack of English ability. Some respondents indicated client acceptance of immigrant caregivers is tenuous and trust can be easily undermined.

Employment challenges: fieldwork findings

While all employers, without exception, stated that they could not run their health care facilities without the foreign-born staff, some employers pointed out challenges in managing foreign-born nursing staff, including differences in educational backgrounds and communication styles that pose some challenges and require additional on-the-job training, Employers also stressed cultural differences in nursing care. For example, in the Philippines, nurses tend to downplay bad situations and not talk openly about mistakes. This leads to problems in the United States because everything must be done according to strict regulations. For instance, the Filipino Nurses Association is currently working with nurses who got into trouble because of a cultural habit that is common in the Philippines. Namely, in the Philippines, the nurses often make the mistake of anticipating the needs of the patient. There was a situation where a Filipina nurse took out medicine in anticipation of a patient's needs. The patient ended up not taking the medicine and the nurse forgot to return the drugs. When she realized she still had the drugs she made a further mistake of not calling the hospital because she was timid and afraid of what might happen. She ended up being accused of stealing the drugs and she lost her license. The association turned the unfortunate event into a learning experience.

While assertiveness and some cultural practices may be an issue, Philippine nurses are widely recognized for their exceptional abilities to nurture, show compassion, and interact effectively with patients.

Workplace relations

Hiring a foreign-born worker could create management challenges and tensions in the workplace. Yet, when we asked, one-quarter of the employers responded that the "quality of care provided" by their organization had actually improved as a result of the hiring of immigrant workers. Conversely, 70 responded no change. This sentiment did not vary between home care companies and nursing home/assisted living facilities. For the most part, respondents wrote that they held all of their staff to the same high levels of the quality of care provided regardless of their nativity.

Those who responded that immigrants had no impact on quality of care, nevertheless, noted some benefits. Many explained that without immigrants, critical staffing levels would not have been met and that a larger applicant pool enabled them to choose the best workers.

> *Employment of immigrants has helped in increasing the number of people to choose from. They are very coachable and eager to learn* (Nursing Home, Suburban, Kentucky).

> *Ninety-five percent of the workers in this facility are foreign. There would be no facility since American-born health care workers are so rare* (Nursing Home, Suburban, State Not Mentioned).

The small percentage of respondents indicating that the quality of care had worsened attributed the decline to communication difficulties, which can greatly affect clients' perceptions on the quality of care. In one instance, the communication problem was primarily between the immigrant caregiver and the professional residents who they reported to:

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

Yet, when asked another question about the "result of hiring immigrants on staff relations," the large majority of respondents, more than 75 percent, indicated that staff relations had "not changed" as a result of hiring immigrants. Some indicated that staff relations were not affected because qualified and hardworking staff members are appreciated regardless of their status.

> *[There are] generally good relationships between cultural groups, but some do keep to themselves. [This] has not hurt employee relations but has not enhanced [them] either* (Nursing Home, Urban, Missouri).

> *Immigrants and non-immigrants get along as long as they all do their jobs* (Nursing Home, Urban, Minnesota).

On the one hand, the 8 to 9 percent of employers who felt staff relations had worsened once again mentioned language and communication issues as the root cause of the problem. On the other hand, the roughly one in seven of employers responding that staff relations had improved attributed it to increased diversity. They wrote that they had multicultural staff members that tended to respect each other and they value the different assets brought by a diverse workforce.

Workplace relations: fieldwork findings

According to the Filipino Nurses Association in Arizona, there are isolated incidents of animosity, resentment, or prejudice between U.S. and foreign-born nurses. Members of the association feel that they have been overlooked in the past for promotions. It is particularly difficult to break into supervisory roles for Philippine nurses. Hospital administration usually cites "communication" as a reason why foreign-born nurses are passed by for promotions. However, the association representatives stressed that this is not a frequent occurrence. The nurses interviewed also stressed that "communication" does not necessarily mean language ability, but rather ability to be assertive.

In one assisted living facility in Arizona, the research team was told that the they go back to the tenets of the United Church of Christ, the congregation

with which this particular facility is affiliated, which call for acceptance of all religions and persons. The administrators we interviewed said that the migrant workers do tend to interact more with staff with similar backgrounds. Some time ago, about a year and a half, the facility had a staff turnover rate of 30 to 40 percent. As a result the administration has taken significant steps to increase morale at the worksite with a flattening of the administrative decision-making process and increasing rewards and recognition for people that did good work.

CONCLUSION AND POLICY IMPLICATIONS

The future demand for foreign-born workers in long-term care is likely to increase because of the demographics of our aging society, i.e., the increasing numbers of elderly and a decreasing population of natives in the working ages. This means, of course, that there will be a declining ratio of native workers available to care for the elderly and that raises concerns of shortages of caregivers or changes in the quality of care. In fact, this report has demonstrated that immigrants are already an important part of the care workforce and, to date, their role has been relatively uncharted. On the one hand, immigrants' presence in the long-term care workforce reflects ongoing demographic changes, but it also reflects past changes in health care and immigration policy. And while it is likely, as the Institute of Medicine has concluded, that reinforcing trends in demographics and health care policy will further increase tomorrow's demand for immigrant labor, the role of immigrants and immigration policy has not been well defined. These conclusions highlight what we have learned about immigrants' current role in caregiving and makes recommendations about health care and immigration policies relevant to immigrants' future role.

We find that the foreign born already play an important role in the supply of workers in long-term care. To some degree that is abetted by America's health care policies, which have reinforced a trend toward the provision of elder care in home care settings, the sector in which immigrants, both direct and professional care providers, make up the greatest percentage of workers. The foreign

born are important in the provision of direct care where they are more than one-fifth of the workforce that provides 80 percent of all long-term care. Among professional care workers they tend to be somewhat under-represented among nurses and therapists overall; yet, they are highly concentrated in the home care industry. As many as half of the nurses in home care are foreign born. We can only speculate about why home care employs so many migrant workers, but it is likely that there is a convergence of lower skill requirements with lower wages and particularly so when home care is privately funded. As is the case in many other sectors of employment, America's ample supply of low-skilled immigrants is an innate fit for demand in the direct care of the elderly and in home care especially.

Native workers tend to gravitate to higher paying sectors within the long-term care industry, but even so our research reinforces the impression that there are too few natives attracted to the industry generally speaking. Indeed, both our fieldwork and online survey found that employers report problems in attracting and then retaining workers. The future supply of both native and foreign-born workers may, in no small part, be ensured primarily by addressing the relatively low earnings in the LTC industries. Better wages and working conditions would certainly help address those problems. Employers report that natives are difficult to attract precisely because they can find better paying employment in other industries. At the same time, our research found that foreign-born LTC workers earn slightly more than their native-born counterparts. Precisely why that is the case is unknown, but their earnings are higher even after a statistical regression controlling for experience, language, and educational differences. At the least, it appears that the foreign born, even if sharing in the depressed earnings characteristic of the LTC workforce, neither experience overt wage discrimination nor are they likely to depress the earnings of natives.

In part, immigrants may fare relatively well in eldercare because – as our research found in our fieldwork and online survey – employers perceive them as being exceptionally caring of their elderly clients. This in no way detracts from

the strong commitment that natives also have for caring for their elderly clients, but it was such a consistent response that it is worth special note. One additional possibility worthy of further investigation are hints that suggest that migrants may have lower turnover than natives and, therefore, earn slightly more because of longer tenure with their employers. At the same time, our research found that the particular cultural and linguistic skills of foreign caregivers make them valuable in the provision of care to foreign-born elderly persons. Because the foreign born are a substantial proportion of America's elderly population, foreign caregivers are important for this client niche. The concentration of foreign-born caregivers in metropolitan areas, especially in central cities, may partly reflect their existing employment to provide care to elderly immigrants. It certainly makes them a first-in-line supply of labor to care for elderly immigrants who reside in central cities in large numbers.

As far as their pathways to employment, direct and professional care immigrants tend to follow somewhat different career tracks. These differences reflect both the nature of the job markets for direct versus professional care workers, as well as the immigration admission system. There are both permanent and temporary visas available for nurses and the numbers admitted are substantial if not as great as some employers would like. Immigrants who come to the United States on working visas are sponsored by employers who must complete highly regulated permanent green card or temporary visa applications. Most foreign-born professional care workers – predominantly nurses in our study – are either trained abroad or seek training after arriving in the United States. The statutory and regulatory framework for such admissions poses considerable challenges for employers of health care professionals alike. Our respondents spoke of waiting up to four years for immigrant visas. While some of this time was spent on preparations for licensing exams, backlog and statutory limits on employment-based visas have also hindered timely admissions. Given these barriers, when employers seek foreign-born workers for professional care jobs they are increasingly turning to recruiters to help them deal with immigration regulations.

In contrast, direct care workers are found primarily though word of mouth referrals. Most low-skilled migrants come as family members of sponsoring U.S. residents or as refugees and they find their way into the LTC employment after arrival. In turn, the formal nature of admissions and employment for professional caregivers likely explains the minute percentage that is unauthorized, while the more market driven job networks in the lesser-skilled direct care workforce likely explains why one-fifth is unauthorized. Our findings indicate, however, that licensing and training requirements in the more formal sections of the direct care system encourage employers to seek workers with legal status.

The pathways that direct and professional care workers take, given the current immigrant admission system, are not likely to change. Some professional caregivers may receive their credentials from a U.S. institution, but most get their degrees abroad so the visa system will continue to apply to most. As for increasing the number of professional caregivers, the current visa system has appropriate classes of admission, but with very little exception, nurses or therapists are not overtly favored over other highly skilled occupations. They are as likely to gain admission through employer sponsorship as other occupations. Given the disfunctionality of the current immigration system, though, this does not say a lot about the prospects for using immigrant pathways to address future shortages. In order for the number of professional care workers to be increased through immigrant admissions more employers must seek to sponsor them than employers seeking foreign workers for other occupations. That has not been the case thus far as foreign nurses are not, on average, a high percentage of the U.S. nursing workforce, unlike say the high percentage of immigrants among U.S. scientists and engineers. Yet, the immigrant admission system may further discourage admission of LTC nurses precisely because it tends to require bachelor level education or training above that typically found among nurses in the LTC sector.

In lieu of changing dynamics in immigrant sponsorship, an increase in foreign nurses could be encouraged through the admission system only by setting aside special visas for professional caregivers, or designating those occupations to be in shortage and thereby facilitating their admission without prior tests of

the labor market. The former approach requires legislation which has been and remains under consideration by the U.S. Congress either in packages of comprehensive reform or special legislation for nursing occupations (albeit with no particular focus on eldercare). The latter change in designating long-term care jobs to be in shortage requires regulatory action by the U.S. Department of Labor which would streamline and increase employer sponsorship. Thus far, that regulatory change has not been forthcoming as it has been difficult to unambiguously identify occupational shortages. Future immigration reform may ease admission for entire classes of highly skilled immigrants, but until then it is difficult to make a case for singling out visas for foreign nurses and therapists since they are no more likely to be in shortage than other highly skilled occupations. More importantly, a better long-run solution to potential future shortages would be to increase the capacity of domestic training institutions which, being understaffed and under funded, are turning applicants away. While there is strong disagreement by experts in the health care industry as to the extent of nurse shortages today, there is widespread agreement that nursing applicants are regularly turned away because there is not enough capacity in U.S. educational institutions.[71]

The lower-skilled direct care labor force has a different dynamic. Foreign workers are a higher than average percent of the direct care workforce which may well reflect a relative shortage of native workers, especially given that foreign caregivers earn more than natives. But in contrast to the case for professional caregivers, there is practically no avenue for targeting their entry through the permanent system and effectively none through temporary visas. Rather, almost the entire foreign LTC direct care workforce is admitted either as family members, refugees or, to a substantial degree, as unauthorized workers. Without knowledge of the proportion of the workforce that is unauthorized, one can only surmise that because it is an older workforce whose pay is commensurate to natives, it is predominantly legal or work authorized. If that is the case, then there is little reason to argue for the creation of targeted visas. Moreover, there appears to be considerable consensus as to the need to increase wages and improve working conditions for all workers within this sec-

tor as evidenced by the Institute of Medicine report cited above. If the desire is to increase the earnings of workers in this sector, then increasing the supply of newly admitted foreign-born workers – who might depress wages – would appear short sighted.

If meeting the demand to educate and retain the domestic nursing workforce should be a priority, changes to immigration policy might nevertheless be required if shortages are clearly identified. Having argued that there are statutory and regulatory bottlenecks in current immigration policy, along with a lack of a well-defined pathway for the admission of LTC workers especially in direct care, it should be acknowledged that targeted changes to admission policies may be necessary. They might favor professional caregivers specialized in long-term care settings either by designating those jobs to be in shortage or by tailoring visas that favor their temporary or permanent admission. This would, of course, require legislative change on the part of Congress.

Recommendations

Our research finds several important steps that should be taken to improve the labor market for foreign-born LTC workers.

First, the admission of nurses and therapists is increasingly being driven by professional recruiters. While other nations have dealt with recruiters for some time, this is a relatively new phenomenon in the United States. We strongly encourage the adoption of voluntary codes of conduct by recruiters, as well as ongoing review and evaluation of the recruitment industry. Where the United Kingdom and other European nations have devised policies to regulate recruiters, the United States has only recently begun to address that challenge. Recommendations on best practices exist that provide a solid base for ongoing improvements.[72] The evaluation teams should include foreign-born nurses and direct care workers.

Second, our research found that employers fairly consistently found that foreign nurses required training to familiarize them with U.S. standards of practice. Even more so, communication and language problems exist and

require training. Proactive employers will undertake the necessary training, but we encourage government support for training programs either through direct funding or tax breaks to community colleges or businesses. Classes in communication and worksite skills, cultural competence, and diversity training should be available for both professional and direct care workers.

Thirdly, our findings suggest several such points of conflict in the workplace between foreign- and native-born workers, as well as possible frictions between immigrant caregivers and their elderly clients. Greater sensitivity and training should be explored to improve employers' ability to work in a diverse work site and to handle possible conflicts between workers and their elderly clients.

Fourthly, we support the Institute of Medicine's calls to improve the professionalization of the direct care workforce. Certification should be required of both a broader array of workers (other than those who receive payment though government programs); as well there should be an enhancement of today's often minimal certification requirements. These steps would improve the working conditions of care workers, help to increase the earnings of all eldercare providers and, ultimately, improve the delivery of care given America's elderly.

Our research also leads us to believe – drawing on widespread perceptions of current and pending shortages of LTC workers – that the management of U.S. immigration should be improved.

The legal admission system should be reformed to improve access to professional, as well as direct care workers if evidence of shortages are convincingly shown to the U.S. Congress.

The creation of visas that target health care workers should be coupled with funding and improvements of domestic educational institutions.

If large temporary programs for low-skilled workers are implemented, they should ideally be for a visa that permitted two to three years stay in order to facilitate continuity of care for the elderly clients of these caregivers.

APPENDIX ONE: SOURCES OF FUNDING

The Atlantic Philanthropies (UK, Ireland, and international collaboration)

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Alfred P. Sloan Foundation (USA, for the research on temporary worker programs)

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Rockefeller Foundation (USA, for the use of the Bellagio conference centre)

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APPENDIX TWO: WEB SURVEY METHODOLOGY

The web survey was conducted using Surveymonkey.com, a web survey company that allows researchers to create, edit, and analyze surveys. Several different types of survey questions are available and users can control the flow of the survey using skip logic. Furthermore, we were able to control the look of the survey in terms of color scheme and question appearance. Data from the survey were exported for analysis into SPSS.

The use of web surveys similar to the one used in this research has proliferated rapidly with the growth of the Internet. The rapid growth of the Internet, both in size and number of users has afforded the opportunity to create web accessible surveys to reach a large number of individuals as research subjects for a relatively small cost.[73] The increased use of the web for surveying has led to more than 30 web-based survey companies now offering services to aid in this process.[74] While the use of web-based surveys has become more common among social science researchers, it poses distinct advantages and disadvantages. Within the realm of our possible options, which were limited by fixed resources and time constraints, the research team took steps to maximize the benefits and minimize the drawbacks of using a web-based survey for research.

Web surveys represent a double-edged sword for researchers in that they are easy to carry out in terms of cost, design, and timeliness on the one hand, but on the other, there is a significant risk that they may be of lower quality, as measured by traditionally accepted survey indicators. The principle challenge for survey researchers is to ensure proper coverage of the target population and minimize both nonresponse rates and measurement errors.

While proper coverage, adequate response rates, and accurate measurement are all crucial elements to probability sample, this research employed a convenience sample consisting of university students at non-U.S. based institutions. The target sample was reached using two methods, with one proving much

more effective than the other: (1) collaboration with professional associations who distributed the web survey to their members via email; (2) use of Dunn & Bradstreet's Rapid Reach email service to target administrative and managerial professionals in the health care field. We took measures to minimize coverage error, nonresponse rate, and measurement errors.

Coverage

Some experts have described coverage error as the single largest disadvantage of web surveys.[75] Coverage error is defined as the discrepancy between the target population and the frame population.[76] The target population is the population targeted for research and the frame population is "the set of persons for whom some enumeration can be made prior to the selection of the sample."[77] Coverage error occurs because some members of the target population may not be members of the frame population. There are two problems with web surveys in this regard: (1) not all members of the target population may be active web users and (2) there may exist a mismatch between the target and frame populations with regard to the "substantive variables of interest," in this case, opinions on issues related to the role of foreign-born workers in the nursing home and long-term care industries.[78]

Coverage error presented a minimal problem for this research because there are some organizations, especially in the home care industry, without access to or limited knowledge of the internet. Research on web survey response indicates that online samples tend to be young, male, and college students. While we did not ask about the age and sex of the respondent, we assumed that individuals with hiring or managerial roles in the nursing home and home care industries would be predominantly middle age and more female than male. We were concerned that many of the respondents who received the notice for the web survey may not have had experience hiring immigrants. The research team controlled for this element by asking whether the subject's organization had ever hired immigrants and then controlling the flow of the survey according to the response.

Nonresponse rates

Nonresponse error occurs in situations where not all the people in the sample are willing or able to complete the survey.[79] Nonresponse error, as with coverage area, is a function of both the rate of nonresponse and of the difference between respondents and nonrespondents on the variables of interest. In our research, nonresponse rate was somewhat difficult to determine because part of the sample was obtained through a convenience method. Nevertheless, the research team took several steps to reduce nonresponse such as:

- Testing the survey several times on different types of web browsers;[80]
- Pre-testing the survey;[81]
- Writing the survey and the invitation email using simple and straightforward language;[82]
- Sending out follow-up reminder emails to complete the survey;
- Sending the survey out on different days and times of day;
- Mentioning that Georgetown University was conducting the research;
- Providing contact information for the research team;
- Explicitly asking the participants for their help;
- Providing a rough estimate of the survey completion time;
- Placing a hyperlink in the email to the survey;
- Promising confidentiality in terms of our protection of the information they provided.

Measurement error

Measurement error, which is the deviation of answers of the respondents from their true values on the measure, can also plague web surveys as well as other surveys that are self-administered.[83] Measurement error arises from either the respondent or the survey instrument itself. The respondent can cause measurement error if they do not comprehend the question, lack the motivation to complete the survey, or deliberately distort the survey. The survey itself can lead to measurement problems if it is difficult to understand or suffers from technical flaws. In order to minimize measurement errors the research team made the survey instrument and the invitation email short and easy to understand and promised to maintain confidentiality.

Despite our best efforts to minimize measurement error, there were several instances where an individual began the survey but did not finish it, was outside the target population, or intentionally tried to distort the survey. Fortunately, we were easily able to filter out all of the incomplete and distorted survey responses.

ENDNOTES

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36. Studies find that when the opportunity is available, from 40 percent to almost 80 percent of participants in consumer-directed programs hire relatives to care for them. Job satisfaction and stress are equal to or more positive for consumer-directed workers than for those who are agency-based. See Benjamin, A.E. and Matthias, R. (2004). Work-life differences and outcomes for agency and consumer-directed home-care workers. The Gerontologist 44: 479-488.
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40. Other categories include large numbers of persons adjusting status in the United States, including 55 percent of immediate family of U.S. citizens.
41. Smaller numbers enter under the O visa (extraordinary ability in the sciences, arts, education, business, or athletics), P (artist or entertainer), Q (cultural exchange and training), and R (religious workers). In addition, there are visa categories for officials of foreign governments, foreign journalists, and officials of the United Nations and other intergovernmental organizations. Professionals, managers, and executives may also enter under the North American Free Trade Agreement.
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45. The TN also permits entries from Mexico; however, there were fewer than 5,000 Mexican admitted on TNs in 2008. Thus, the TN is predominantly a vehicle for Canadians and the use of the TN by Mexicans for work in health care occupations is also unknown.

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47. Temporary lifting on the program for J physicians in under-served areas may have accelerated a switch of physicians under the J to the H-1B visa.
48. We would like to thank Dr. Jeffrey Passel of the Pew Hispanic Center who provided these estimates for the long-term workforce. Note that these estimates are considered reliable because independent samples indicate that most unauthorized individuals are included in U.S. Census samples (for methodology, see Passel, J.S., Van Hook, J. and Bean, F.D. 2006. Narrative profile with adjoining tables of unauthorized migrants and other immigrants, based on Census 2000: characteristics and methods, Report to the Census Bureau, Sabre Systems: Alexandria, VA, http://www.sabresystems.com/whitepapers/EMS_Deliverable_1_020305.pdf.
49. Why this is so we do not know, but it may be that the TN and other modes of entry are more readily available for skilled Canadians.
50. These estimates were also kindly generated by Dr. Jeffrey Passel of the Pew Hispanic Center. See discussion in text and for methodology see op cit. Passel et al. 2006.
51. More than one-quarter of the ACS sample lives in metropolitan areas where central city status is unknown. Nevertheless, foreign-born LTC workers are twice as likely to live in central cities as natives out of individuals whose central city residence can be identified – 39 versus 18 percent respectively.
52. Both Phoenix and Washington, DC, the sites of this project's fieldwork, are included in these top two dozen foreign-born LTC cities of residents.
53. Pearson correlation = 0.95 between the number of persons ages 65 and older with the total number of direct care workers in metropolitan areas.
54. Los Angeles and New York are America's largest cities. During the latter 1980s and 1990s there was significant out migration from both New York and Los Angeles which likely further concentrated their remaining elderly populations. In Los Angeles, foreign-born Latinos also left the city during the 1990s. In New York, the out migration of natives was significant and lasting. An influx of new migrants, particularly from the Caribbean and elsewhere in the Americas, generated rebounding population growth. It is possible that the concentration of foreign-born LTC workers in New York evolved out of these offsetting migratory trends.
55. U.S. Census Bureau, United States Foreign-born population tables, Census 2000, http://www. census.gov/population/www/socdemo/foreign/STP-159-2000tl.html.

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57. Op cit. Stone and Dawson 2008.
58. Both names have been changed to protect the identity of the health care providers.
59. For more information, see Fagen, P. and Hickling, H. (2008). Source country health workers: the case of Jamaica. Source country report for the Institute for the Study of International Migration, Georgetown University.
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63. Ibid.
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65. But nurses are deterred from seeking employment for other reasons; several respondents expressed dismay about the litigious nature of U.S. society and the pressure health care workers face from possible law suits.
66. The survey employed skip logic which allowed only those respondents who had employed immigrant workers to answer the series of questions regarding experience with immigrant workers.
67. Physical, Occupational, and Speech Therapists.
68. Aides, Nursing Assistants, Medical Assistants, and Orderlies.
69. Yet, very few respondents stated that they were uncertain about the legal statuses of their current employees. Employers tended to indicate that their immigrant workers have a legal status, 41 responding that “most” of their immigrant workers were naturalized citizens, 27 percent that most were legal permanent residents, and another 10 percent legal temporary workers. Interestingly, 10 percent reported that “most” of their immigrant workers had no status, while another 5 percent reported that they did not know. While the U.S. experience is that legal status is not a major deterrent to inclusion in samples, it is not surprising that employers in this type of online survey would tend to respond conservatively about legal status.

This is a useful question, but it sheds little light on the actual percentage of workers who may be unauthorized.

70. Foreign nurses not educated in the United States must complete either the Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate or pass the NCLEX examination in order to practice in the United States. Misunderstandings about the process can cause difficulties, leading some employers to hire outside recruiters or employment contractors to take care of their foreign-born work force needs.
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