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Ageing and Care Giving in the United States: Policy Contexts and the Immigrant Workforce

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Abstract The ageing population of the United States is generating an increasing demand for care and foreign-born workers will supply an important part of that demand. This article discusses the ways in which U.S. healthcare and immigration policies affect the supply of the foreign born to professional and lesser skilled, direct care jobs. The U.S. market for long term care is shifting away from hospitals and institutionalised facilities to the direct provision of private services and long term care in homes. A well designed immigration policy would complement the demand generated by the healthcare system. Yet, there are few dedicated avenues of legal admission that select for professional care workers and none at all that target direct care workers. There is concern over shortages of professional workers and a substantial number of unauthorized workers in direct care work that flag deficiencies in immigration policies. Our examination of data, nevertheless, finds that the foreign born play an important role in the supply of workers. In the provision of direct care they are roughly one-quarter of the workforce that provides 80% of all long term care. Among professional care workers they are highly concentrated in the home care industry. These national-level concentrations, however, do not fully reveal the remarkable concentration of immigrants in just a few metropolitan areas.

Keywords Eldercare · Long-term care · Healthcare policy · Immigration policy · Immigrants · Labor force · Occupations

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Introduction: Eldercare in the U.S. Context

The ageing population of the United States is generating an increasing demand for care and foreign-born workers will supply an important part of that demand. In 2007, the Institute of Medicine (IOM 2008) in the United States charged an ad hoc Committee on the *Future Health Care Workforce for Older Americans* to assess the health care needs of U.S. residents aged 65 and over. The committee conducted an in-depth analysis of the health care workforce by reviewing education and training, models of care, and public and private programs for health care workers engaged in caring for the ageing population of the U.S.. The IOM's resulting report finds that as the population of seniors grows to approximately 20% of the population in the next couple of decades, they will face a health care workforce that is too small and critically unprepared to meet their needs. Little is known about the role that immigrants play in supplying care for the elderly, so this article sets out to better understand how U.S. policies structure their role and, in turn, the characteristics of the foreign born in its labor markets.

Long term care for elderly U.S. residents is a patchwork of public and private sector policies and programs that have evolved over time. As is often the case in the United States, there is no comprehensive national policy on healthcare and there are significant differences across states and even metropolitan areas. Long-term care includes a variety of services and supports provided by unpaid (informal) and paid providers, concentrating on helping individuals to function as well as possible in the face of disability. While U.S.'s immigration policy has a clearly defined set of principals, it too has come to resemble something of a patchwork that is unresponsive to demands for highly skilled workers, while failing to control a substantial supply of low-skilled and unauthorized workers. The Federal government controls the national flow, but the distribution of immigrants across states and urban markets varies significantly. Ultimately, the concentration of immigrants by skill level and the places where care is given is shaped by the combination of policies on healthcare funding and policies on immigrant admissions.

New trends are emerging in the U.S. market for long term care. There has been a movement away from hospitals and institutionalised care facilities to the direct provision of private services and long term care in homes. While long term care includes other than the elderly, discussion about care of the elderly in the United States typically focuses on the provision of long term care which is primarily about care of the elderly. Roughly two-thirds of the elderly live with others in a household with about one-seventh living with their children. Yet, almost three-tenths live by themselves and the remainder lives in group quarters such as nursing homes.[1] This has led to rapid growth of the workforce in non-institutional settings while the workforce in institutional care has remained relatively stable. We have seen a robust growth in the workforce of *direct care* providers—home health aides and lower-skilled providers—in the long term care industry. The supply of *professional care* workers—practitioners, nurses, and therapists—has grown but moderately in

[1] Group quarters are living arrangement for institutional groups with ten or more unrelated persons including, in the case of the elderly, some hospitals, rest homes and, increasingly, nursing homes (IOM IOM Institute of Medicine 2008).

comparison. In turn, immigrants have become an important part of the professional and especially the direct care workforce.

The last major changes in U.S. immigration policy were enacted between two and five decades ago; and the system favors family reunification and relatively few immigrants are admitted to meet changing labor market demand. Immigrants in both professional jobs and in lesser skilled direct care jobs are involved in long term care. Direct care workers are the front-line workers in caring for ageing U.S. residents. Their job tasks include duties such as bathing, dressing, toileting and assisting the ageing with the "activities of daily living" (ADLs). The Bureau of Labor Statistics (2007) projects that personal and home care aides, and home health aides will be the second- and third-fastest growing occupations in the United States between 2006 and 2016. Workers in these positions fulfill direct service-oriented tasks and have the most contact with the elderly. While U.S. immigration policies do not appear well designed to supply immigrants to these discrete job types they, nevertheless, result in a significant supply of foreign-born workers. To date we know very little, however, about the demographic characteristics and attributes of these workers relative to other occupations in the long-term care industry. Indeed, we know very little about the foreign born in this industry.

This article investigates U.S. policies, those for eldercare and immigrant admissions, and how they affect the role of the foreign born in long term care. Our research is part of a four nation, collaborative project involving Ireland, the United Kingdom, Canada and the United States.[2] The aim of that project included an exploration of the implications of migrant workers for the delivery of health and social care to older people, for the living and working conditions of the migrant caregivers, and for immigration and integration policies. 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 article draws on Census samples to describe both the direct and professional care workforces in long term care industries, focusing on the countries that supply immigrant workers, and their geographic distribution in the United States.

Sources of Funding, Care Settings and the Eldercare Workforce

Long term care is bound up in three domains or a "triple knot" of its financing, setting, and workforce (Stone and Sanders 2008). The elderly and their families expend significant amounts on their care, although public funds pay for the majority of services in nursing homes and for poor individuals. More and more acute care services formerly provided in hospitals are being provided in skilled nursing

[2] Research partners include the Institute for the Study of International Migration (Georgetown University), 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 & Society (University of Oxford), which is the international project coordinator. See http://www.compas.ox.ac.uk/research/labourmarket/migrantcareworkers/. Accessed 17 August 2009.

facilities. Cost pressures and preferences are making less medically intensive institutions, such as residential care and private homes, the care setting of first recourse. And while most services are provided by unpaid family and friends, a workforce of both professional and direct care providers plays an increasingly significant role. This changing context reinforces demand for both skilled providers and especially for lesser skilled caregivers.

Sources of Financing

Care services are financed by a patchwork of funds from the federal, state and local levels, as well as by private resources, primarily paid from the consumer's own pocket. In 2004, national spending on older adults totaled about $135 billion (Congressional Budget Office 2004). National, public funds accounted for approximately 60% of long-term care spending on the elderly. Out-of-pocket spending accounted for another one third, private long-term care insurance for 4%, and various other federal, state, and local agencies for most of the rest.[3]

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% in 1990 to 34% in 2002 (Congressional Budget Office 2004). 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. The national average annual cost for assisted living was $35,628, while care purchased outside of an institution typically is less. 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 private, unregulated 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% of all long-term care spending on the elderly in 2004 and 40% of spending for nursing home care (Congressional Budget Office 2004). In 2005, nursing home care accounted for 63% of total Medicaid spending on long-term care (Burwell et al. 2006). Although the federal government established 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. State spending for Medicaid long-term care per elderly person varies widely (Merlis 2004). In fiscal year 2001, estimated state spending (excluding federal matching funds) ranged from $61 per elderly Louisianan to $1,323 per elderly New Yorker. Some of this variation is attributable to difference in the federal share of Medicaid spending, prevalence of disability rates among the elderly, and other factors. State coverage and reimbursement policies, however, are the most important differentiating factors.

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

[3] These estimates do not place a value on the vast amount of unpaid care, including the value of wages forgone by informal caregivers that is estimated to have cost $350 billion in 2006 (Gibson and Houser 2006).

to offer personal care services under their state plans (Smith et al. 2000). In 1981, Congress authorised the waiver of certain federal requirements to enable a state to provide home and community services. By 2005, 37% of Medicaid long-term care expenditures covered home health, personal care and home and community-based services (Burwell et al. 2006). Over the period 1992–2005, expenditures for these services grew at a rate of 15% per year, more than double the rate of growth for the overall Medicaid long-term care expenditures (Fox-Grace et al. 2006). However, Medicaid policies remain biased in favor of nursing home care. In 2006, only seven states spent 40% or more of their Medicaid long-term care financial resources on home and community-based care (Kassner et al. 2008). A number of states (Alaska, California, Minnesota, New Mexico, Oregon, Texas and Washington) have taken the lead in attempting to rebalance the long-term care system away from institutional care toward more home and community-based care options.

Medicare

The federal Medicare program provides health insurance to almost all people age 65 or older. It financed 20% of national long-term care expenditures in 2005, including 16% of nursing home care and 27% of home health care (Feder et al. 2007). 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 4% of the elderly population's long-term care in 2004. In that year, 29% of long-term care insurance policies in force were held through employer-based programs (America's Health Insurance Plans 2007). Although they offer significant advantages over individual policies, in most employer plans the policyholder pays the entire premium. It. is estimated that only 6 to 9% of eligible employees take advantage of the employer-based plans.

Thus, while the elderly and their families pay for much of their own care and increasingly some are turning to private insurance, public funds and private insurance cover most care. In either event, cost containment is important as personal funds tend to be limited and insurers and government have budgets to balance. When the elderly pay out of pocket the regulations covering their employees are few, e.g., there need be no training requirements and the consumer may seek the least cost care. At the same time, the growing cost of healthcare for the elderly puts pressures on the public programs to seek lower cost ways of providing care. These trends coincide in shifts in the settings where long term care takes place, particularly settings that employ direct care workers which is where most immigrants are found.

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 and one's own home as the least restrictive setting. Along the continuum, there are also different care requirements with nursing homes needing more skilled workers, on balance, than the workforce in homes. Funding sources also affect training requirements as public funds set certification requirements which are higher for institutionalized care settings.

Nursing Homes and Residential Care

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

"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, which may provide some assistance in daily activities or simply convenient meals, are large buildings that strongly resemble hotels or nursing homes in physical appearance and philosophy. Other residential care options are small, homely settings that offer privacy and choice to residents (Stone 2006).

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 (Mollica 1998). Board and care homes are licensed and regulated under more than 25 different names; many more are unlicensed. Most homes provide three meals a day and supervision of medication.

Adult foster homes are small-group, residential settings housing typically between three and six individuals (Kane et al. 1998). 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 undertakes to arrange for personal care and routine nursing services (Wunderlich and Kohler 2001). When the concept was first operationalised 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 of homelike accommodations.

There are also over 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 (Commission on Affordable Housing and Facility Needs for Seniors in the 21st Century 2002). 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 subsidised housing properties (Harahan et al. 2006).

Adult Day Care

The number of adult day service providers has almost doubled from 2,000 in 1985 to 3,500 in 2002 (Wake Forest University School of Medicine 2002). Twenty-one percent of adult day centers are based on the medical model of care, 37% are based on the social model with no health-related services; and 42% are a combination of the two. Over 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 8 h.

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 health care includes skilled nursing and assistance with personal care. Home care tends to be non-medical and includes personal care. In 2007, there were 9,284 Medicare certified home health agencies (National Association of Home Care and Hospice 2007). Home care is the largest segment of the long term care workforce and includes broadly speaking jobs, in officially classified settings, such as these agencies in home healthcare services, as well as jobs in private households and individual and family services. The place or setting of care and its associated means of income, obviously, generates demand for particular workers with particular skill sets.

The Providers of Care

Across all settings there are both informal and formal caregivers for the elderly and much of 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 policymakers, it remains true today. These informal caregivers, sometimes referred to as paraprofessional workers, dominate the smaller group of paid providers. At the same time, in the formal market professional workers provide medical care and supervision, tasks that are intensive but allocated across many clients. So the greatest numbers of

providers in the formal market are the direct caregivers on the frontline of daily care for the elderly.

Informal Care

Nearly all, about 95%, of non-institutionalised elders with long-term care needs receive at least some assistance from relatives, friends or neighbours. Almost 67% rely solely on unpaid help, primarily from wives and adult daughters. As disability increases, elders receive more and more informal care. Some 86% 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 over 14 h of paid assistance. Almost 75% of the primary caregivers are women; 36% are adult children; 40% are spouses.[4] It has been estimated that between 30 and 38 million adult caregivers provided care to adults with limitations in 2006 (Gibson and Houser 2006).

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. 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 (Harahan and Stone 2009).

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 primary attendants of the elderly, as well as the "high touch" providers in all long-term care settings (Stone and Wiener 2001). 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 (Center for Health Workforce Studies 2005).

To become certified as a nurse aide, federal law requires less than two weeks' 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

[4] Given that the average age of the informal caregiver is 60, the majority of primary informal caregivers do not hold paying jobs. Among the 31 percent who are in the labor force, two-thirds work full-time. Employed caregivers provide fewer weekly hours of assistance than non-employed caregivers, but they still invest, on average, 18 hours per week. Two-thirds of working caregivers report conflicts between jobs and caregiving that caused them to rearrange their work schedules, work fewer paid hours or take leaves of absence (usually unpaid) from work.

direct care workers, including those who work in assisted living, home care agencies or are independent providers. Typically, the staff in these settings receives little or no training (Harahan and Stone 2009).

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 data bases. 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.[5]

Recruiting and, more importantly, retaining direct care workers have become a major issue for providers, workers, consumers, and policymakers at the state and federal levels. While the magnitude and distribution of workforce shortages cannot be accurately assessed, there is considerable evidence that shortages are overwhelming the long-term care system. A national survey found that two thirds of US states reported shortages of certified nursing assistants and 60% reported shortages of home health aides (Moore 2006). At the same time, one study of nursing home staffing found an annual turnover rate among directors of nursing and other RNs of about 50%; 15% of RN positions were vacant (Decker et al. 2001). The causes of turnover are many, including low provider to client ratios, little control over work, and the demands of shift work and low wages. So a perception of a shortage of caregivers is compounded by high staffing turnover.

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. Organisational philosophy and management style, wages and benefits, quality of the work environment and interpersonal dynamics affect the successful development of the direct care workforce (Stone and Dawson 2008).

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, including older workers and former welfare recipients. Providers have implemented a range of interventions including culture change activities to create a healthier work and care environment, peer mentoring programs, career ladders for professional development and promotion opportunities,

[5] 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 (Benjamin and Matthias 2004).

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 jobs are low-skilled and, for the most part, require little education and training. The "soft skills" of these workers may be quite extensive, but they are all too 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 h 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 h 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. Given that these characteristics describe many immigrants in the United States, we should expect them to play a significant role in direct care.

Synopsis

There has been a large shift away from care in nursing homes and into other settings including residential care and home care over the past two decades (Alecxih 2006). By one measure, the percentage of older adults (65+) in nursing homes declined from 4.2% to 3.6% between 1985 and 2004 with the steepest drop among adults age 85 and older. The decline can be attributed to a healthier and wealthier elderly population and, over the last decade, increasing alternatives to nursing homes such as residential care, assisted living, and more home-based services. States and federal Medicaid funds have increasingly favored the provision of care in less medically intensive settings by providing more community- and home-based care, while the growth of private care insurance has also abetted the trend. Changes in the setting of care, in turn, favors the lesser skilled workforce most often found in home care. Still, there is substantial demand for more skilled caregivers who, while more concentrated in institutional caregiving, work in all settings.

Immigration Policy and Pathways into Eldercare

Immigrants follow pathways into both professional and direct care that wind their way through U.S. immigration policy and, after arrival, through different labor market mechanisms. A well designed immigration policy would complement the demand generated by the healthcare system, if not by being having dedicated visas for specific jobs and sectors, then by supplying channels by which appropriately skilled immigrants supply relevant sectors of expanding long term care. As we have seen above, U.S. funding sources, and the settings in which care for the elderly occurs, generate a demand for both professional and particularly for lesser skilled direct care workers. Yet, there are few dedicated avenues of legal admission that select for professional care workers and none at all that target direct care workers.

These differences subsequently contribute to pathways into jobs in eldercare that differ for professional and direct care workers.

Legal Permanent and Temporary Admissions

Permanent immigrants, aka, "green carders" are persons who are entitled to live and work permanently in the U.S. and, after five years, to become naturalised U.S. citizens. The four principal doors for legal permanent admission are family reunification (59%), employment (17%), diversity (5%),[6] and humanitarian interests (18%).[7] While most immigrant adults are likely to find employment, rather few are admitted specifically for the purposes of skilled work and avenues for low-skilled employment are yet more restricted.

Admission for the purpose of employment, predominantly initiated by a sponsoring U.S. employer, is restricted to employment-based visas. The highest priority goes to persons of extraordinary ability, then to professionals with advanced degrees, then to other professionals or skilled workers. Only 10,000 visas are allocated for low-skilled workers. The family category encompasses sub-categories for spouses, children and parents with numerically uncapped and capped classes for persons sponsored by citizens or legal permanent residents. Many family immigrants are employed, some as professional workers, but a majority find employment in jobs requiring low-to-average skills including direct healthcare provision. Likewise, humanitarian admissions are granted for claims of persecution, but refugees and asylum applicants also find employment and some as health- and social-care workers.

The so-called temporary classes of admission, referred to by alphabetic visa designations, also favor highly skilled workers who are sponsored by a U.S. employer. The principal visas for temporary workers are the E visa for traders and investors entering under bilateral treaties, the H1-B for highly skilled specialty workers, the H-1C for nurses in shortage areas, the H-2A for agricultural workers, the H2-B for other seasonal workers, the L for intercompany transfers, and the J for exchange scholars.[8] A substantial number of nurses enter with the skilled H-1B visa, but only a very small number with either the H-1C or H-2B. The skill requirements for the H-2B make it relevant for direct care providers, but it is otherwise irrelevant as it is for seasonal work only.

Data on Admissions in the Healthcare Sector

The legal permanent and temporary classes of admission admit substantial numbers of foreign workers, but favor professional jobs that are likely outside of eldercare.

[6] The small Diversity Program aimed to redress the concentration of immigrants from a handful of origin-countries that resulted from the emphasis on family reunification. Diversity immigrants are chosen by a lottery from applicants who must have at least a high school education or its equivalent.

[7] Admission percentages for the year 2008 for a total of 1.1 million individuals admitted. See the Department of Homeland Security's Yearbook of Immigration Statistics, http://www.dhs.gov/files/statistics/publications/yearbook.shtm

[8] Smaller numbers of primarily professionals enter under other working visas (the O, P, Q and R), as well as classes of admission specified in the North American Free Trade Agreement.

On permanent visas, about 1.5 times as many nurses are admitted as physicians. From 1991 to 1996, the number of nurses admitted averaged 8,564 only to fall to an annual average of 4,815 from 1997 to 2000 (Paral 2004). However, the numbers in the employment-classes alone grew again to 6,625 in 2004 (Jefferys 2005). As only two-thirds of nurses enter on permanent employment visas, this suggests that as many as 9,800 nurses were admitted. While equivalent numbers are admitted on temporary working visas, they also likely supply few workers for the long term care industry. [9] Some 7,022 practitioners and 4,102 other medical workers were admitted on H-1B visas in 2005. The H-1B visa requires at least a Bachelors degree which may be more than that required for many eldercare jobs. More recent data are unavailable and they remain mute on jobs found within just the eldercare industry.

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 that hospitals, nursing homes and other sponsors attest to a number of conditions of employment including the need for foreign workers, wages and working conditions, and that the foreign workers would not affect labor disputes. 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 including operating a training program for nurses at the facility or financing (or providing participation in) a program elsewhere. Ultimately, the H-1A program expired in 2005 after admitting only 6,512 nurses. A somewhat similar successor program, the H-1C program for underserved areas, went into effect in 1999, but has been capped at 500 visas annually. A similar requirement also applies to the J visa for foreign medical graduates for physicians in medically under served areas.[10] Thus, these special purpose visas admit rather few healthcare workers and, because sponsoring employers must be able to bear the cost, one might speculate they are likely to be large hospitals and less often institutions in eldercare.

Unauthorised Migration and Estimates for Long Term Care

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, unauthorised workers initially enter predominantly to seek work in low-skilled jobs. As of 2008, there are estimated to be 11.9 million unauthorised migrants or about 30% of all foreign born (Passel Passel 2006). It is estimated that 8.3 million of the unauthorised population is

[9] There is also the TN or Trade NAFTA visa, admitting perhaps 20-30,000 predominantly Canadians in 2007, which anecdote suggests includes substantial numbers of nurses. Note too that the EB-3 visa recently developed for Australia has a cap of 10,000 visas but thus far has admitted few workers and an unknown of nurses. Altogether, estimates provided by Passel (see discussion above) suggests that there are about only about 37,000 temporary workers on all possible visas among professional long term care providers (0.70 percent of the professional workforce) and effectively none among direct care providers.

[10] 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.

employed and most of these are in low-skilled jobs such as farming, grounds keeping and construction.

Thus, while legal entrants make up the bulk of the foreign-born particularly in the professional long term care workforce, unauthorized workers are a substantial percentage of direct care employment of the elderly. The unauthorised 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 unauthorised status (Passel 2006). 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 unauthorised are 3% of professional foreign-born workers and 21% of foreign-born workers in direct care of the long term care of the elderly.[11] So the unauthorised are an extremely small percentage of foreign-born professionals and a minority of direct caregivers. At the same time, while all unauthorised workers are roughly 5% of the U.S. labor force, they are less than 0.5% of all professionals in long term care jobs and just 4% of all long term care direct care workers. This likely reflects the legal admission, as well human resource employment procedures in larger institutions that screen unauthorized professional workers. Unauthorised workers are more successful at finding employment in the lesser skilled and lower paying direct care workforce where demand is strong.

Accreditation of Foreign Health Professionals

The admission of professional caregivers is affected by accreditation practices, which are governed both by non-governmental bodies and state government policies, and must be addressed prior to admission. 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

[11] Furthermore, their share does not appear to have increased over the last half-decade (see Passel et al. 2006). Note too that these estimates are considered reliable because independent samples indicate that most unauthorised individuals are included in Census samples.

(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.

Pathways to Work in Long Term Care

Admission policy, with its partiality toward highly skilled workers, further conditions the pathways by which immigrants tend to find jobs in professional as compared with direct care. Or course, these differences also reflect both the nature of the job markets for direct versus professional care workers. The admission system, however, by requiring employer sponsorship for skilled workers prior to admission channels most immigrants directly into professional care—and that reinforces the more formalized nature of human resource management for such jobs including the certification requirements just discussed above.

For example, foreign-born professional care workers, nurses by in large, are either trained abroad or seek training after arriving in the United States. Thus, when employers sponsor immigrants for professional care jobs they are increasingly turning to recruiters to help them deal with cumbersome immigration regulations. Whereas there is a perception that recruitment has been common in other countries, it is relatively recent phenomenon in the United States (Brush et al. 2004). According to a 2007 report, there was a "cozy niche" of only 30 to 40 recruitment agencies in the late 1990s while, today, there are over 267 U.S.-based recruitment firms (Pittman et al. 2007). Direct recruitment by hospitals and large assisted living and nursing home facilities is slightly more common than recruitment by third-party agencies. While there are no estimates of the proportion of professional care workers among newly admitted immigrants, much less those explicitly recruited, this is clearly an increasingly important pathway toward employment. Importantly, there are challenges not only in reforming visa admission policies, but also in the certification and recruitment processes that filter professional care workers before they are finally employed.

Employers tend to find direct care workers, on the other hand, primarily through word of mouth referrals. Most low-skilled migrants enter legally as family members of sponsoring U.S. residents or as refugees and they find their way into the long term care employment after arrival. Foreign workers are a higher than average percent of the direct care workforce which may well reflect a relative shortage of native workers. 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, the preponderance of the foreign long term care direct care workforce enters as legal family members or refugees and, to a lesser degree, as unauthorised workers. And the large concentrations of immigrants in direct care jobs, which we present below, indicate that these jobs are being well supplied by these classes of admission—an observation that must be quickly modified by the observation that the unauthorised portion of the direct care workforce may suggest unmet supply through legal channels. In other words, the policy challenges for the direct care workforce lie in reform of the entirety of U.S.

immigration policy, both legal visas and the management of unauthorised migration, as well as in the healthcare policies regulating care settings and working conditions.

Synopsis

U.S. policies on immigrant admission and professional certification, in principle, work relatively well insofar as physicians and registered nurses go. There are both permanent and temporary visas for the admission of these highly skilled caregivers, the accreditation process functions tolerably well, and substantial numbers of professional care workers are admitted annually. On the other hand, while immigrant admission policy does not target lesser skilled, direct care workers the number of legal the legal family and humanitarian immigrants, combined with the unauthorized migrants, evidently provide ample avenues of entry into these jobs that are less regulated by healthcare policy. Nevertheless, a general concern with shortages of professional eldercare workers, and the substantial number of unauthorized workers in direct care work, flags deficiencies in immigration policies. After arrival in the United States the nature of immigrant sponsorship, by employers or families, affects the pathways by which professional and direct care workers find jobs in long term care. These different pathways select for immigrants who, at least among the professional workforce, one can anticipate are well educated and highly motivated. The pathways taken by immigrants into direct care, however, suggest little about their effect on immigrant characteristics and there is little research on the question.

Foreign-Born Workers in Long Term Care

There is a small body of research using data on long term care workers, but surprisingly little of it tells us much about the foreign born. While special surveys and professional associations collect data on skilled nurses and physicians, aside from self-reporting in the census there are no mechanisms for acquiring data and human capital information of direct care workers. Fortunately, the census data include identifiers for immigrant status and so they can tells us quite a lot about their role in the workforce providing care to the elderly. We explore here the large samples taken by the U.S. Census Bureau that are known as the American Community Surveys (ACS). We are able to identify long term care workers in these surveys with detailed occupation and industry codes. In order to get a sufficient sample size, we combine or average results in many cases for the five years from 2003 to 2007. Our examination of these data demonstrates that immigrants are, as anticipated, concentrated in direct care jobs, as well as come from specific countries and reside in a few urban labor markets.

The Long Term Care Workforce in Eldercare

We follow prior research to define direct care workers with selected occupations restricted to long term care industries, but we expand our examination here to

professional care workers in a smaller subset of long term care industries. Like others, we consider lower-skilled direct care providers to be nursing psychiatric and home health aides, as well as personal and home health aides. Professional care workers are employed as practitioners, nurses, or therapists. Practically all direct care workers are, by definition, in long term care and so we consider any employment in seven long term care industries. We define professional care workers as being found in long term care in five of these industries, excluding those employed in outpatient care or in hospitals.

Table 1 shows the native and foreign-born by occupation in the long term care sectors for direct and professional care. The lower panel demonstrates that, of all long term care workers, most are in nursing care facilities (40%) and home health care services (25%). Formal employment in long term care is found primarily in these industry sectors—while a large labor force of informal family members that cannot be identified with these data labor are "off the books" in private households or family services. At the same time, the 16% of long term care workers apparently

Table 1 Long term care workers by occupation, industry and nativity, 2004–2007

Industry	Direct care		Professional care occupations				
	Personal and home care aides	Nursing, psychiatric, and home health aides	Licensed practical and licensed vocational nurses	Registered nurses	Therapists & physician assistants	Practioners	Total
	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 service	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
Occupational workforce (%)	19.8	59.4	8.7	10.3	1.7	0.1	100.0
Occupation workforce (1,000s)	578	1,730	253	300	49	4	2,913

Source: Tabulations of the American Community Survey.

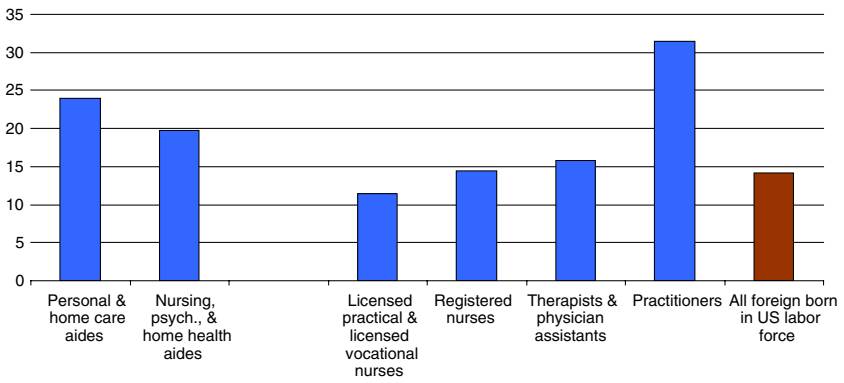
Note: sample size less than 30 observations or, for professional care workers, work in outpatient care and hospitals is not considered long term care.

employed in hospitals is largely due to the mixed nature of the occupational grouping "nursing, psychiatric, and home health aides," which includes long term care workers with aides not so clearly identified. Long term care, by and large, does not take place in either hospitals or outpatient services.

The upper part of Table 1 shows the percent of workers in long term care jobs that are foreign-born (as summarized also in Fig. 1). The greatest concentration of foreign-born workers is in practitioner jobs, as is the case outside of long term care. Nearly one third, 32%, of long term care practitioners is foreign born, but practitioners are less than 1% of the entire long term care workforce. At the same time, the foreign born are under-represented as nurses when averaged across all long term care settings, they are 11% of licensed nurses and are also not a particularly high proportion of registered nurses or therapists. But as we could have expected given the characteristics of direct care jobs, the foreign born are 24% of home health aids and 20% of nursing and psychiatric aides, occupations that employ about 80% of the total long term care workforce. Thus, immigrants are disproportionately concentrated in the low-skill direct care jobs that dominate the long term healthcare sector. Further, Table 1 shows that the relative share of foreign workers is greatest in the private household sector which has generally lower standards of training requirements for frontline workers. Perhaps conditions in this setting partly explain the very high concentration of immigrants in the more skilled nursing jobs within the private household sector where they supply nearly half of all registered nurses. So these data reinforce the expectation that immigrants are most important in supplying the lower skilled jobs in the least regulated and least medically intensive settings in long term care.

Origins and Destinations of Foreign-Born Care Workers

Next, we examine the countries foreign-born workers come from and the cities to which they migrate. The skill composition of immigrants in long term care is associated with the skill composition of the countries from which they come, or put in other terms the countries that supply immigrants in eldercare are mostly



Source: Tabulations of American Community Survey

Fig. 1 Percent of long term care workers who are foreign born, 2004–2007

the same as those which supply higher and lesser skilled jobs economy wide. At the same time, immigrants after arrival in the United States show well-known settlement patterns, but immigrants in long term care appear to have distinct patterns that may result from the unique regional demand.

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—78% of native-born and 86% of foreign-born workers are in direct care. Of course, direct care is the largest workforce in long term care; nevertheless, immigrant workers are yet more likely than natives to be in direct and not professional jobs. There is some diversity among groups. A total of 95% of Mexican born workers are direct care providers as contrasted with a somewhat lesser 70% of Filipino workers. While there is notable variation among immigrant groups, long term care is predominantly about the provision of frontline, direct care and that is the case regardless of source country.

Otherwise, certain source countries tend to be highly represented in the supply of professional as contrasted with direct care. Among foreign-born professional care workers, 37% come from Asian origins, 25% from the Philippines alone, while another 22% come from the Caribbean islands. Africa is the source of 15%, while Canada and Europe together supply just 13% of professional care workers. English speaking countries combined supply only 16% of professional care workers, while countries where English is prevalent, India and the Philippines, supply another 30%. Among foreign-born direct care workers, only roughly one-quarter come from countries where English is spoken. And one half of foreign direct care workers come from the Western Hemisphere; 29% from the Caribbean and 21% from Mexico and Central America. Mexico alone supplies 15% of direct care workers and Jamaica and Haiti supply another 17%.

After arriving in the United States, immigrants in long term care jobs reside, and surely work, in very different places than natives. Unsurprisingly based on what we know about immigrants generally, foreign-born long term care workers tend to live in metropolitan areas, about 96% compared with just 73% of native long term care workers.[12] 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.[13] The elderly population is more likely to live in rural areas than the population at large and, thus, native care providers likely service the rural elderly to a greater degree than do foreign-born care providers. The urban population of elderly, however, is more likely to be in some cities and the distribution of immigrants in long term care may be closely associated with the demand generated by urban elderly.

[12] See source for Table 3: American Community Survey (ACS)

[13] Over one-quarter of the American Community Survey (ACS) sample lives in metropolitan areas where central city status is known. Nevertheless, foreign-born long term care workers are twice as likely to live in central cities than are natives out of individuals whose central city residence can be identified—39 versus 18 percent respectively. It is possible that the many elderly living in central cities drive some of the demand that leads many foreign-born workers to also reside and work in central cities.

Table 2 Selected countries of birth of foreign-born long term care workers, 2003–2007

Region and nation of birth	Share in each occupational group by nationality, %			Share of total US workforce, %		
	Direct care workers	Professional care workers	Total	Direct care workers	Professional Care workers	Total Count
Total	79.2	20.8	100.0	100.0	100.0	2,917,229
US 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
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

Table 2 (continued)

Region and nation of birth	Share in each occupational group by nationality, %			Share of total US workforce, %		
	Direct care workers	Professional care workers	Total	Direct care workers	Professional Care workers	Total Count
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.

There is, in fact, a high correlation between the number of elderly and the corresponding long term care workforce in U.S. metropolitan areas.[14] Indeed, the foreign-born long term care workforce lives in very different cities than other immigrants. Table 3 ranks the leading metropolitan areas of native and foreign-born workforces separately. Approximately two-thirds of the professional caregivers and three-quarters of social caregivers live in just 24 metropolitan areas and, surprisingly, roughly one-quarter of all foreign-born long term care workers reside just in the New York metropolitan area. In contrast, just one-quarter of native long term care 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 resides there. And, for example, the greatest numbers of the United States' elderly population 65 years of age and older live in New York followed closely by Los Angeles, Chicago and Philadelphia, etc., and these are the cities with the largest long term care workforces. While we cannot readily explain why long term care immigrants are hyper-concentrated in New York, we can observe that the foreign-born tend to be a very high percentage of the long term care workforce in leading metropolitan areas.[15]

Synopsis

Our exploration of survey data on foreign-born workers in the U.S. long term care workforce shows that their greatest concentrations are found in home care settings and the provision of individual and family care. Both large proportions of foreign-born

[14] Pearson correlation=0.95 between the *number* of persons aged 65 and over with the total *number* of direct care workers in metropolitan areas.

[15] 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 long term care workers in New York evolved out of these offsetting migratory trends.

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

Top 24 native-born metropolitan areas (percent of all natives in each metropolitan area)				Top 24 foreign-born metropolitan areas (percent of all immigrants in each metropolitan area)			
Metropolitan area	Direct care	Professional care	Foreign born share	Metropolitan area	Direct care	Professional care	Foreig nborn share
Total metropolitan count (1,000 s)	1,887	540	–	Total metropolitan count (1,000 s)	512	85	–
Total metropolitan share (percent)	100.0	100.0	19.8	Total metropolitan share (percent)	100.0	100.0	19.8
New York-Northeastern NJ	3.5	3.2	65.8	New York-Northeastern NJ	28.1	21.5	65.8
Chicago, IL	2.2	1.9	29.2	Los Angeles-Long Beach, CA	10.5	8.1	63.1
Detroit, MI	1.8	1.1	9.4	San Francisco-Oakland-Vallejo, CA	4.1	2.3	57.5
Philadelphia, PA/NJ	1.7	2.8	17.2	Chicago, IL	3.2	5.5	29.2
Los Angeles-Long Beach, CA	1.6	1.1	63.1	Washington, DC/MD/VA	2.8	5.3	55.0
St. Louis, MO-IL	1.3	1.1	2.2	Boston, MA-NH	2.7	2.9	38.6
Dallas-Fort Worth, TX	1.2	1.1	18.1	Miami-Hialeah, FL	2.5	2.5	73.6
Minneapolis-St. Paul, MN	1.1	1.3	22.7	Fort Lauderdale-Hollywood, FL	1.9	2.2	67.4
Pittsburgh, PA	1.1	1.3	3.9	Riverside-San Bernadino, CA	1.6	1.7	33.3
Houston-Brazoria, TX	1.1	1.0	22.8	San Diego, CA	1.5	1.4	45.3
Cleveland, OH	1.0	1.4	6.4	Philadelphia, PA/NJ	1.5	2.6	17.2
Boston, MA-NH	0.9	1.7	38.6	Seattle-Everett, WA	1.5	1.4	46.8
Riverside-San Bernadino, CA	0.9	0.5	33.3	Houston-Brazoria, TX	1.3	0.8	22.8
Baltimore, MD	0.8	1.1	13.9	Minneapolis-St. Paul, MN	1.3	1.6	22.7
San Francisco-Oakland-Vallejo, CA	0.8	0.5	57.5	San Jose, CA	1.1	1.4	69.4
Atlanta, GA	0.8	0.7	23.1	McAllen-Edinburg-Pharr-Mission, TX	1.1	–	48.5
Phoenix, AZ	0.8	0.9	21.1	Sacramento, CA	1.0	–	40.5
Milwaukee, WI	0.7	0.6	4.0	Dallas-Fort Worth, TX	1.0	1.4	18.1
Tampa-St. Petersburg-Clearwater, FL	0.7	1.0	22.4	West Palm Beach-Boca Raton, FL	0.9	1.2	54.6
Washington, DC/MD/VA	0.6	0.6	55.0	Phoenix, AZ	0.9	0.8	21.1
San Antonio, TX	0.6	0.5	16.0	Atlanta, GA	0.8	1.3	23.1
Greensboro-Winston Salem, NC	0.6	0.5	1.7	Tampa-St. Petersburg-Clearwater, FL	0.8	–	22.4
Cincinnati-Hamilton, OH/KY/IN	0.6	0.9	3.0	Brownsville-Harlingen-San Benito, TX	0.7	–	46.9
Buffalo-Niagara Falls, NY	0.6	0.7	1.5	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.

workers are found in these settings, as compared with hospitals or nursing homes, and they make up significant percentages of the workforce in these settings. These national-level concentrations, however, do not fully reveal the remarkable concentration of immigrants from particular sources, say the Caribbean and Mexico in direct care, or the Caribbean and the Philippines in professional care. At the same time, the foreign born are further concentrated in just a couple of dozen metropolitan areas, which suggests that they are a less important workforce in rural or small metropolitan areas.

Conclusions

The future demand for foreign-born workers in long term care is likely to increase because of the demographics of the United States' ageing society, reflected by the increasing numbers of elderly and a decreasing population of natives of working age. The U.S. Bureau of Labor projects that direct care jobs will be the second fastest growing segment through to 2016 and one can readily extrapolate growing demand beyond that date. Further, the provision of eldercare has been moving toward home care which is the setting in which immigrants, both direct and professional care providers, make up the greatest percentage of workers. Indeed, the foreign-born already play an important role in the supply of workers in long term care. They are important in the provision of social care, where they are over one-fifth of the workforce that provides 80% 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. Between one third and one half of the licensed and registered nurses in home care are foreign born.

There will be increased future demand for both professional and, especially, for direct care workers in selected cities and economic sectors. One can certainly see a targeted demand for foreign-born caregivers. Of course, the slowing supply of native-born workers due to demographic ageing, combined with the increased numbers of elderly, will tend to generate opportunities for foreign-born workers in long term care. 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 mentioned above, much of this targeted demand is likely to occur in the homecare sector, which has been encouraged by shifts in the nature of U.S. funding for eldercare. On the one hand, this raises red flags because earnings in homecare tend to be less than in other sectors. On the other hand, government funding for homecare opens a window of opportunity for regulating job certification requirements and wage guidelines that can improve working conditions. 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 long term care industries. Better wages and working conditions would help attract workers into these jobs. There must be a careful balance between the supplies of foreign-born workers—an oversupply of whom might depress wages and for whom it is difficult to devise special visas—and reform to the healthcare industry and its payment systems, which is the primary mechanism for improving workers' wages.

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