

Migration and the future of care

Supporting older people and care workers

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March 2022

Key messages

Many high-income countries are facing a rapidly increasing demand for older persons' care, alongside huge workforce shortages. Workforce shortages are directly linked to the sector's low pay, poor working conditions and the undervalued nature of care work. These stem from the feminisation of care work, including paid employment, and the impact of more recent austerity, privatisation and marketisation trends.

Migrants are essential to the delivery of older persons' care in many high-income countries, often filling gaps left by inadequate formal care systems. They also help to make care affordable for those who would otherwise go without support. However, they are more likely than local workers to encounter low pay and poor working conditions, particularly if working in home care, and if undocumented.

Few examples of labour migration pathways exist that bring in sufficient numbers of older persons' care workers who are able to work under fair employment conditions. Where pathways have been used, careful design is required to guard against the exploitation of these workers and to ensure continuity of care.

Countries need to make the sector more attractive to local workers. However, recruiting migrant workers appears to be the only way to provide safe and high-quality care for older people, both now and in the medium term as countries age rapidly. Ensuring ethical and sustainable international recruitment should be an immediate policy priority.



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How to cite: Kumar, C., Dempster, H., O'Donnell, M. and Zimmer, C. (2022) *Migration and the future of care*. ODI Report. London: ODI (www.odi.org/publications/migration-and-the-future-of-care).

Acknowledgements

This paper benefited immensely from extensive internal and external comments and suggestions. In particular, the authors would like to thank Professor Shereen Hussein, Maria Vincenza Desiderio, Ana Llana-Nozal, Angelina Del Rio Drake, Robert Espinoza, Abigail Hunt and Francesca Bastagli for peer review, as well as Denielle Amparado, Olive Leonard, Reva Resstack, Kelsey Ross, Diego Faures and Shelby Bourgault for research assistance. We are also grateful to Anna Brown for editorial support, Elizabeth Tribone for coordinating the production of the report and Anil Shamdasani for typesetting and design. Opinions and any errors or omissions remain the responsibility of the authors.

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Executive summary

As people age, many find themselves in need of dedicated, long-term care. This demand has rapidly increased in recent decades; there are more older people and, as social structures shift, they are less able to rely on their families for support. How to adequately finance, structure and staff long-term care systems is therefore a pressing question of global concern.

Many high-income countries are already facing severe workforce shortages. The low wages, poor working conditions and lack of up-skilling prevalent in the older persons' care sector¹ make jobs unattractive, leading to major challenges in the recruitment and retention of local workers. The Covid-19 pandemic has exacerbated these challenges. While some countries have created labour migration pathways to attract international migrant workers, the promotion of ethical and sustainable migration for older persons' care remains a neglected issue.

This report, produced by authors at ODI and the Center for Global Development (CGD), analyses the intersection between the older persons' care sector and migration. It looks at the experience of migrant workers and the patterns of mobility for older persons' care between countries. It also provides three case studies – China, the United Kingdom (UK) and the United States (US) – to better understand how governments have sought to support older persons' care systems and address workforce challenges. The report

concludes with recommendations to policy-makers in high-income, rapidly ageing countries that are struggling with these issues.

Key findings

Older persons' care systems and workforce shortages

There is great diversity in the policy responses to older persons' care needs. Some high-income countries have high levels of formal care, with large workforces staffing residential institutions and providing home-care services. Others have increased access to paid long-term care, mainly by expanding the private market for home care using 'cash-for-care' allowances. Many countries are striving to rebalance care systems away from expensive institutional care options towards home-based care delivery, with 'cash-for-care' schemes supporting this broader trend. Mixed public and private provision is common, with the private sector increasingly dominating care systems as privatisation and marketisation trends accelerate. Expanding private equity involvement in the sector is also notable. However, older persons' care systems remain heavily reliant on public funding; without it the costs of care would be unaffordable for many.

Demand for long-term care is outpacing the growth of the long-term care workforce in more than half of OECD countries. Keeping the current ratio of long-term care workers to older people

¹ This paper uses the term 'older persons' care'. This was chosen to reflect the decision taken by the United Nations (UN) Committee on Economic, Social and Cultural Rights to use the term 'older persons' as opposed to the term 'elderly' when referring to people aged 65 and above, given that the term 'elderly' is considered inaccurate and misleading.

would mean increasing the number of workers across the OECD by 13.5 million in the next 18 years – an increase of 60% on average over 2016 levels.

Workforce shortages are also the result of the unattractive and undervalued nature of care work, no doubt linked to the feminisation of care employment. Older persons' care is persistently, and inaccurately, characterised as 'low-skilled' and workers are among the lowest-paid in high-income societies. Across the OECD, care workers are paid around the minimum wage and significantly less than similar occupations in other settings. The trend towards more home-based care has brought additional problems, as it is less regulated, more informal and noted for worse pay and conditions. More precarious forms of employment, based on zero-hour contracts and temporary agency work, are also on the increase. As long as these issues remain, large supply gaps seem likely to persist.

Migrant workers and the older persons' care sector

Migrant workers are already essential to the delivery of older persons' care. More than a fifth of the long-term care workforce in the OECD is foreign-born – and this is likely an understatement, given the large informal care workforces. Migrants are employed in all settings, public and private, from residential homes to home-care agencies and within households. Evidence suggests that migrant workers are frequently overqualified for their roles and more highly skilled than the local workforce. Migrants help to reduce labour shortages and improve the well-being of older people; emerging evidence from the US has found that migrant labour is associated with improved quality of care in nursing homes and with lower rates of use of institutional

care. It is also clear that there are benefits for migrants and their families, in the form of increased wages and remittances.

However, migrant workers – who are usually middle-aged women from low- and middle-income countries – are more likely than local workers to encounter substandard wages and working conditions, and may struggle to access social protection. Workers who are undocumented are more likely to face such issues, along with mistreatment. These concerns are most acute in home care, notably due to its invisible nature. Few countries actively monitor workforce conditions within the industry; regulators mainly focus on assuring care quality standards, with workforce issues largely outside their remit.

Migration pathways and international recruitment into the sector

Many migrants in the older persons' care sector were attracted through migration routes such as free movement agreements, family, humanitarian and student migration. However, while free movement arrangements have facilitated the availability of much-needed workers, combined with underdeveloped formal systems of care and a preference for cash allowances, they appear to have also contributed to a large informal market for older persons' care in some countries.

Just a few OECD countries – Canada, Israel and Japan – have implemented targeted labour migration pathways for older persons' care workers. Australia is also exploring ways to use its general labour migration pathway to attract older persons' care workers to rural and remote areas of the country. These pathways have benefits and drawbacks for migrants. If migrant workers are required to 'live in' or be tied to one employer, the risk of exploitation increases. Most workers

are not able to bring their families, which affects the well-being of the migrant and the family. Their migration can also lead to ‘care drain’, reducing the number of potential carers in low- and middle-income countries.

High-income countries must therefore pursue the ethical and sustainable international recruitment of older persons’ care workers in a way that safeguards these workers and recognises the impact of movement on their countries of origin. Doing so will imply some new challenges for high-income countries. These include the lack of professional accreditation standards, the lack of established workforce regulators and the need to monitor recruitment activity in the fragmented landscape of multiple private providers.

Future recruitment should be in line with the World Health Organization’s *Global Code of Practice on the International Recruitment of Health Personnel*, which requires ‘mutual benefit’ from health worker migration. As such, high-income countries should invest in health workforce training and skill-upgrading in low- and middle-income migrant countries of origin. Many of these countries are around 20 to 30 years behind high-income countries in terms of demographic ageing trends. As a result, ‘mutual benefit’ could focus on immediate priorities related to underdeveloped health systems and workforces, but should also seek to strengthen the older persons’ care sector in countries of origin in the medium-to-long term. New partnerships and migration programmes – and new thinking around the training, skills and certification systems necessary to support these – will be required. This should be a focus of attention for the global public health community and development partners over coming decades.

Conclusions

Understandably, there are concerns that older persons’ care systems in high-income countries rely too much on migrant labour and that this dependence could discourage the overdue structural reform of the sector. While there is no question that countries need to make the older persons’ care sector more attractive to the local workforce, there is unlikely to be a short-term, easy fix. Further, given the scale of workforce challenges, investing in improving the sector alongside the continued recruitment of migrant workers appears to be the only way to provide safe and high-quality care for older people as high-income countries rapidly age. Recognising that much attention has already been devoted to the investments and reforms needed to improve older persons’ care systems, we offer recommendations that are narrowly focused on harnessing migration channels and supporting migrant workers as a way to strengthen care services for older people.

Recommendations to policy-makers

- Make it easier for older persons’ care workers to migrate, through both general migration schemes and targeted pilots. These migration pathways could provide either long-term temporary visas – with a view to encourage circularity and skills-building – or a pathway to permanent residency and citizenship.
- Ensure that migration pathways provide a ‘mutual benefit’ to the country of origin. Within bilateral government-to-government agreements, financial and technical assistance can be provided to address immediate priorities and could, if well targeted, contribute to the establishment of sustainable and comprehensive long-term care systems in countries of origin.

- Ensure that visas include family accompaniment and are not tied to one employer. Migrant workers should not be expected to leave their families at home, nor risk exploitation and abuse.
- Ensure that migrant care workers benefit from the same range of entitlements as non-migrant care workers, including full labour and social protections. Creating dedicated agencies to monitor home-based working conditions is likely to be necessary to deliver improvements in this area.
- Strengthen qualification recognition and ensure harmonisation with countries of origin. Recognised qualifications and career enhancement pathways are essential for the professionalisation and improvement of the older persons' care workforce. These systems must also ensure that migrants can have their skills recognised and can easily pursue work in the older persons' care sector at home or abroad.
- Gather data on the older persons' care workforce and publish it regularly. This should include disaggregated information on the workforce (by gender, age, country of nationality/birth, educational qualifications, skills/certifications), and on turnover, retention, vacancies, contract types, pay and conditions. These efforts can inform the balance between local and international recruitment and workforce development strategies.

1 Introduction

As people age, many find themselves in need of dedicated, long-term care. The number of people requiring care has rapidly increased in recent decades, as the world population ages demographically. Some countries such as Japan, Italy, Spain and Germany have long been at the forefront of this trend. Others such as the Republic of Korea, Singapore and China are also experiencing significant demographic shifts which will ensure they meet, or even surpass, many European countries in the next 20 years. How to adequately finance, structure and staff long-term care systems is therefore a pressing question of global concern.

In high-income countries, broader societal shifts, including women's increasing participation in the paid labour force and the evolution of cultural norms around caregiving, mean that older generations are no longer able to rely exclusively on the unpaid care support of younger family members. As a result, many older people are coming to rely on care services outside the family sphere. Yet, in these countries, low wages, poor working conditions and the lack of up-skilling that are prevalent in the older persons' care sector make frontline jobs unattractive. This creates challenges for recruiting and retaining local workers for these roles. As part of the response to labour shortages, many families and care facilities in high-income countries have therefore turned to international migrant workers. Some countries have created specific legal labour migration pathways dedicated to the admission

of migrant workers into care occupations, while other countries admit such workers under generic labour migration systems.

Despite these trends, and the spotlight shone on the sector by the Covid-19 pandemic, very few studies have attempted to explore in depth the intersections between long-term care and international migration. This report, produced by ODI and the Center for Global Development (CGD), aims to provide clear and actionable recommendations to policy-makers in high-income, rapidly ageing countries that are struggling with these issues.² Previous research has explored how high-income countries can improve wages and working conditions in their older persons' care sector, thereby making it more attractive to locals. In this report, we seek to add to this literature by exploring how the sector can also be strengthened through the promotion of ethical and sustainable migration to meet older persons' care needs. We ask how existing patterns of care work migration will be impacted by the demographic shifts that are affecting all countries, including migrant countries of origin. We also make the case for why this policy issue requires immediate attention.

The analysis is structured within the following five sections.

Section 2 analyses the older persons' care sector. It outlines demographic ageing trends in countries around the world that are experiencing increasing demand for care services. It explores

² We also include China, which though an upper-middle income country, is experiencing a particularly significant challenge due to the scale and speed of population ageing, aligning its policy context with that of higher-income countries.

the approaches to care delivery and key trends, the shortages within the sector's workforce – and the drivers of these shortages – and how countries have attempted to respond to them. (See Box 1 for a discussion of terminology and definitions related to the sector, which are used throughout this paper).

Section 3 analyses migration for older persons' care. It begins by exploring broad patterns of mobility between countries of origin and destination, and how these patterns may change

in the future. It outlines the experience of migrant workers in the older persons' care sector: what skills they have, where they work and what wages and conditions they operate under. After exploring the benefits and drawbacks of this migration, the section concludes by analysing the different strategies that high-income countries have used to attract migrant workers into this sector, as well as how to ensure there is ethical and sustainable international recruitment of care workers for older people.

Box 1 Terminology, definitions and data

This paper uses the term '**older persons' care**'. This was chosen to reflect the decision taken by the United Nations (UN) Committee on Economic, Social and Cultural Rights to use the term 'older persons' as opposed to the term 'elderly' when referring to people aged 65 and above (UN CESCR, 1995). The term 'elderly', while still in common use, is considered inaccurate and misleading, automatically implying frailty (Avers et al., 2011). As such, the terms 'elderly' and 'elderly care' are avoided in this report.

Long-term care (also known as social care) refers to care for older people and care for younger people with disabilities. Generally, services are organised and managed separately for both groups, although policy, financing and workforce challenges are shared. This report focuses only on older persons' care but refers to the long-term care workforce frequently, given that data is generally not disaggregated for older and younger age groups who are receiving care.

Institutional care refers to all situations when older people reside permanently in institutions, whether nursing homes, residential care facilities or assisted living facilities.

Home-based care (or **home care**) refers to older people receiving care in their own homes to assist their daily living activities and enable them to live independently.

The formal **long-term care workforce** consists of a mix of occupations and functions covering all caregiving and support roles in all settings (e.g. both institutional and home-based care). It should be noted that the workforce generally does not include those who work in hospitals and hospital workers are not the focus of this report.

Personal care workers make up the majority of workers in the long-term care workforce and are found in all institutional and home-based settings. These workers are the focus of this report. Different terms are used for personal care workers in different countries. They are often simply referred to as **care workers** in this report or senior care workers where this specific job classification is relevant.

Domestic workers are employed in private households, often performing household chores as well as providing direct care for children, older persons or those with disabilities. As such older persons' care workers in household settings can be, though are not always, domestic workers. Some may work under live-in arrangements. This group makes important contributions to care for older people and migrant domestic workers face particular challenges. However, significant data gaps for this population limit our ability to reflect their specific needs and constraints in this study. They are a limited focus of the report only (see Box 6 and the China case study).

The **long-term care workforce data** discussed in this report mainly refers to the formally employed. These workforce estimates are larger than just those who work in older persons' care, though in OECD countries the majority (79%) of long-term care recipients are older adults (OECD, 2019). OECD data is commonly used for country comparisons. Where countries are relying on high numbers of migrant workers working informally within the home, these workers will not show up in workforce statistics.

Source: King-Dejardin, 2019; OECD, 2019; OECD, 2020; ILO, 2021a

Sections 4 to 6 aim to ground this global discussion in specific contexts through three case studies – China, the United Kingdom (UK) and the United States (US) – to better understand how governments have sought to support older persons' care systems and their workforce challenges. The case studies look at current policy debates in all three countries, particularly in relation to migration for this sector. We prioritised these countries for several reasons. First, while all are rapidly ageing, they have not been at the forefront of such trends and are comparatively younger than countries such as Japan and Italy. As a result, they are only now facing up to the scale of their demographic challenge, and thus have an opportunity to act pre-emptively, instituting reforms that meaningfully shift how

the older persons' care sector operates. Second, all have had restrictive immigration policies, with few opportunities for low-paid workers to be admitted. There is therefore merit in stimulating debate around whether all three countries can use immigration policies more effectively to meet older persons' care needs.

The final section provides a succinct summary of lessons learned from the review of literature and the case study countries' experiences, before concluding with targeted recommendations that focus specifically on the intersection between older persons' care and international migration.

2 The older persons' care sector

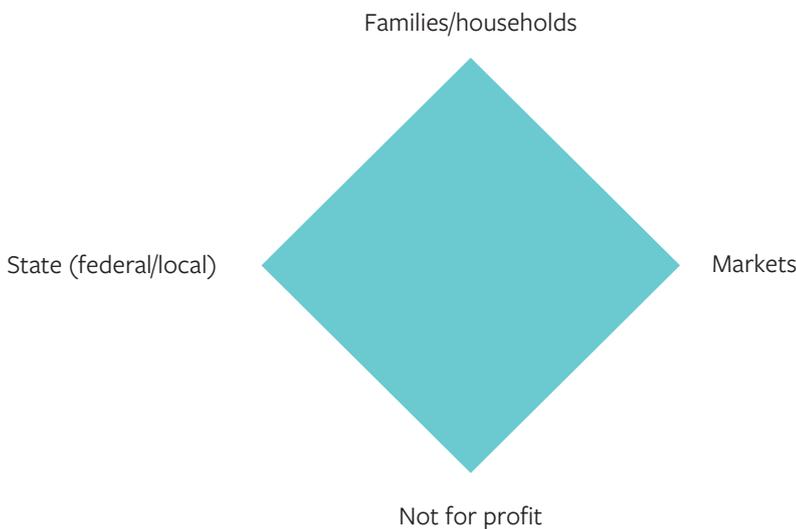
2.1 The care economy, paid and unpaid care

Care for older people sits within the broader ecosystem of paid and unpaid care work. Women and girls – especially those from traditionally marginalised groups based on race, ethnicity, caste or other demographic characteristics – perform the significant majority of this work, paid and unpaid. The International Labour Organization (ILO) defines care work as two overlapping activities: ‘direct, personal and relational activities, such as feeding a baby or nursing an ill partner; and indirect care activities, such as cooking and cleaning’ (ILO, 2018: 1). This includes care for older people, as well as children, the sick and those living with disabilities. Care work can support the physical health, nutrition and hygiene needs of those receiving care, as well as their mental health, socio-emotional and cognitive development, and their broader well-being.

The care economy has been conceptualised by Razavi (2007) through a ‘care diamond’ (Figure 1), which includes the care work performed by family/

household members, within the private sector (market), the public sector (state) and the not-for-profit sector. Care work can be redistributed across the diamond – and importantly, transitions across the care diamond are not uni-directional as countries develop (i.e., from private provision through family and voluntary schemes to public provision offered through markets and government services). Instead, allocations across the care diamond are dependent on other factors, such as the level of political will to support care responsibilities through the public sector, the level of development of the not-for-profit or private sector, or context-specific cultural norms around caregiving within extended family networks. Further, as discussed below, evolving policy responses due to the rising cost pressures of older persons’ care also play a role in reallocating the distribution of care across the care diamond. This report focuses on paid care work, which is performed both within formal and informal economies, and both inside and outside the home (e.g., hiring of home-care workers; relying on nursing homes).

Figure 1 Razavi’s care diamond



Source: Razavi, 2007

Box 2 The undervaluation of care work

As of 2018, there were 647 million full-time unpaid carers worldwide – 94% of whom were women (ILO, 2018). Care work is essential for the functioning of households, communities and economies, yet it remains undervalued. The low status, low pay and poor working conditions in the paid care sector are an almost universal feature. The justification for low pay is clearly intertwined with traditional gender ideologies that undervalue work that has traditionally been done by women (Razavi, 2007).

In order for gender equality to be achieved – and in particular for women to have equal opportunities to access quality jobs with labour protections – shifts will need to be made along the ‘care diamond’ from families/households to other entities, whether through state provision, the market or the not-for-profit sector. Men and boys also have a role to play in taking on more unpaid care responsibilities within households, redistributing this work away from women and girls.

The number of hours of unpaid care performed to support older people still exceeds the hours of paid care, even in high-income countries with more developed, formal long-term care systems (ILO, 2018). In addition, in many countries, the number of unpaid carers far outweighs the size of the formal care workforce. The OECD reports 10 times as many unpaid carers compared to paid workers in Canada, the US, the Netherlands and New Zealand, and even twice as many in Denmark, a country with a well-developed formal system (Colombo et al., 2011). A high reliance on unpaid carers has significant impacts, mainly borne by women, including a reduction in labour market participation as well as leaving unpaid carers facing a higher risk of poverty and mental health problems (ibid.). It is worth noting that older women are not only recipients of care but often are (paid and unpaid) care providers themselves. Previous ODI research reflects that, across 30 countries, older women spend more than four hours a day on unpaid work (more than double the time spent by older men), while the proportion of older women in the paid economy has also risen at a faster rate than that of older men since 1990 (Samuels et al., 2018).

During the Covid-19 crisis, the time that women especially spend on unpaid care has increased significantly; quarantine measures have restricted women’s ability to rely on schools, childcare centres and other care services outside the household (Kenny and Yang, 2021). Women who have left the paid workforce or have reduced paid working hours due to care responsibilities will be slower to re-enter the workforce without targeted intervention – thus undoing pre-Covid gains in women’s labour force participation and economic empowerment (O’Donnell et al., 2021).

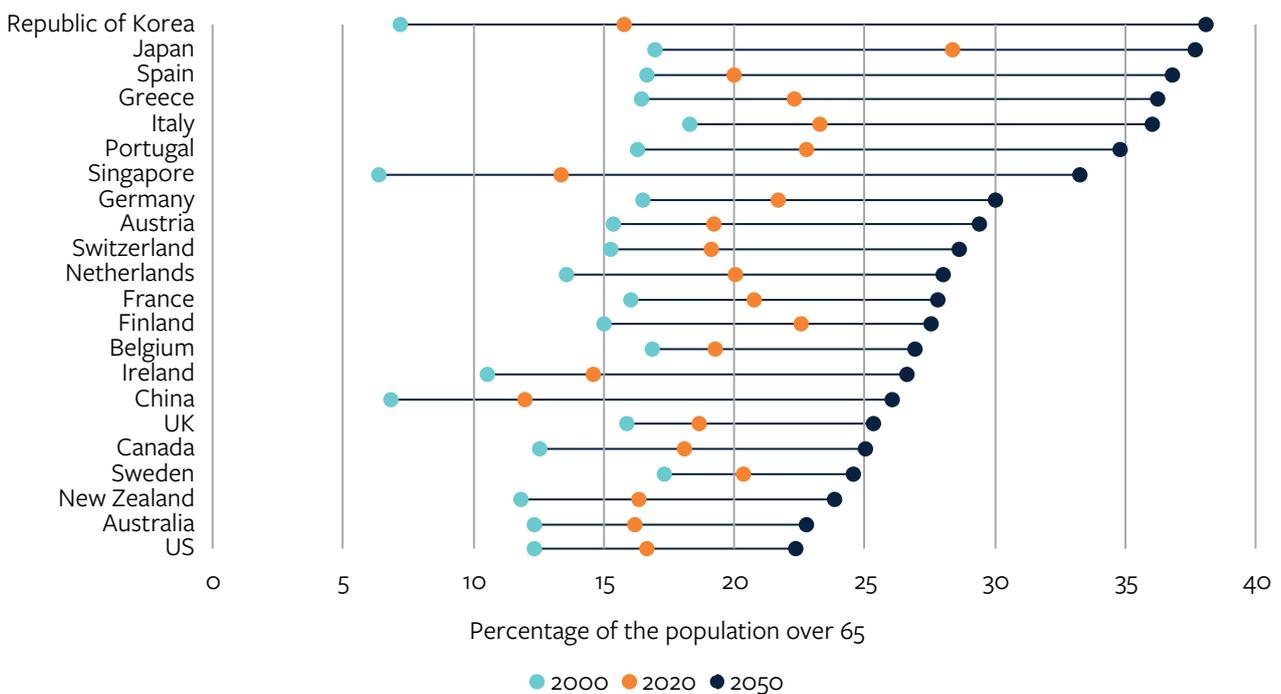
2.2 The increasing demand for paid care

The impact of ageing is notable across all high-income countries. Some locations particularly stand out (see Figure 2). Countries such as the Republic of Korea, Japan, Spain, Greece, Italy, Portugal, Singapore and Germany are forecast to have more than 30% of their population aged 65 and over by the year 2050. Demographic trends in Asia are particularly marked, with countries such as the Republic of Korea, Singapore and China experiencing extremely rapid ageing since the year 2000.

Demographic ageing is not the only driver behind the rapidly increasing demand for care among older people in high-income countries. It is also affected by factors including low fertility rates, women’s increasing participation in the paid labour force, changing family structures (with the

role of the traditional extended family reducing and families having fewer children), and increased mobility resulting in greater distance between generations (Peng and Yeandle, 2017; ILO, 2018). The impact of ageing on demand for care is also not entirely straightforward. Older populations are becoming healthier, but population ageing is also associated with higher rates of survival with chronic illness and complex conditions (HelpAge International, 2017). In particular, the rapid increase in the number of people with dementia across OECD countries – forecast to rise from more than 21 million in 2021 to nearly 42 million by 2050 – will create additional demands on the sector (Colombo et al., 2011; OECD, 2021). Challenges also increase enormously with advanced age. It is estimated that around 40% of those aged 85 and older need high-level care compared to 8% of people aged between 65 and 74 (Johnson, 2019b).

Figure 2 Ageing trends in selected countries, 2000–2050



Note: This figure uses UN DESA estimates for data up to 2020 and UN DESA ‘medium variant’ projections for population ageing by age group after 2020.

Source: UN DESA Population Division, 2019

In light of the factors outlined above, paid care services have come to represent an increasingly important sector of the economy and one that employs significant numbers of workers (Razavi, 2007). However, high-income countries are experiencing major problems with the access to, coverage and quality of their care sectors (ILO, 2018). Only a small number of high-income countries have legislation that provides for universal, needs-based care services for older people and many countries have some means-testing requirements (*ibid.*). Overall, there is broad consensus that long-term care policy responses in high-income countries have been developed in a piecemeal, reactive manner and that the needs of older people have remained a low priority on the policy agenda (Colombo et al., 2011; ILO, 2017).

2.3 Changing approaches to older persons' care delivery

2.3.1 Policy responses

There is great diversity in the policy responses to older persons' care needs and the approaches to care delivery across high-income countries. In northern Europe, in countries such as Denmark, the Netherlands, Finland and Sweden, there are high levels of formal, subsidised care and often large care workforces staffing residential institutions and providing home-care services. In Japan, the rapidly ageing population has made long-term care a priority and the country maintains a needs-based and high coverage system. The UK and the US are examples of countries with more restricted and means-tested access to care services (ILO, 2018). Canada is somewhat similar, given that long-term care is beyond the scope of health insurance services, though means-testing and access vary by province (Commonwealth Fund, 2020).

Italy and Spain, which have traditionally relied heavily on family care, have increased access to paid long-term care mainly by expanding the private market for home care using 'cash-for-care' allowances. While Spain passed legislation on universal access to long-term care in 2006, its implementation was derailed by budget cuts after the global financial crisis, leaving an over-reliance on the use of cash allowances instead of direct provision of services (Peng and Yeandle, 2017). Within this private market for home care, both Italy and Spain rely heavily on migrant domestic workers with migrant workers often living in to take care of older people (Gori, 2012; Van Hooren, 2014).

Similar approaches are taken in Portugal and Greece (ILO, 2018), though Portugal is also noted for the very strong presence of not-for-profit providers (Eurofound, 2020). In Singapore, tax concessions are offered to families to employ foreign domestic workers to provide care for older people (Peng and Yeandle, 2017), while in the Gulf States the lack of publicly provided long-term care services has also led to a reliance on migrant domestic workers, often living within families (ILO, 2018). In China, the older persons' care system remains underdeveloped. There is a low level of publicly provided, means-tested coverage only and generally low levels of access to long-term care, given that private options remain unaffordable for many (*ibid.*).

While in some countries (e.g. Denmark and Finland) the public sector plays a major role in older persons' care provision, mixed public and private provision is very common, with the private sector often increasingly dominating care systems. There is no pure separation between market and state, with systems heavily reliant on public funding. The UK, US and Ireland are all examples, with a very high percentage of residential and/or

nursing home care delivered by the private sector but heavily subsidised by public spending (Wren et al., 2017; National Audit Office, 2018; Gupta et al., 2021). The government also plays an important role in regulating private care providers, with Japan notable for its tight regulation of private care provision (Peng and Yeandle, 2017).

2.3.2 Financing long-term care

Older persons' care is similar to healthcare in that it is financed through general taxation or with contributions based on social insurance schemes – or a mix of both. Nordic countries offer universal coverage within tax-funded social care systems and countries such as Germany, Japan, the Republic of Korea, the Netherlands and Luxembourg have dedicated social insurance schemes (Colombo et al., 2011). Across OECD countries, on average 1.5% of GDP was spent on the long-term care sector in 2019 (OECD, 2021). In an analysis across 45 countries, the ILO (2018) forecasts that to expand access to care, and improve wages and care quality, governments would need to increase spending to 2.3% of GDP. Public financing for the sector is critical, given that without it the costs of long-term care would be unaffordable for many, surpassing the median incomes of older people in most OECD countries and raising the prospect of catastrophic costs for older people (OECD, 2021).

2.3.3 Towards privatised and marketised care

Austerity policies have reduced public spending on social services including on older persons' care (ILO, 2018; Van Hooren, 2020). Privatisation and marketisation trends have gone hand-in-hand with a reduction in public spending, with a greater emphasis placed on the market (as well as on the voluntary sector and provision by the family),

implying a redistribution across the 'care diamond' (ILO, 2018). This is particularly visible in the case of the UK where associated practices – such as competitive tendering to commission services – have been heavily critiqued as a key driver of low pay and poor conditions (Fair Work Convention, 2019; see UK case study). However, these trends are widespread, including in Nordic countries, and in East Asia, where rapid ageing in very large populations means the scale of need for care has suddenly exploded in contexts where services are underdeveloped (Peng and Yeandle, 2017). China's struggle to increase services at speed, in the face of enormous need, has prompted the government increasingly to channel funding to private firms to expand older persons' care infrastructure and services (ibid.; see China case study). In general, marketisation trends are also associated with increasing numbers of migrant care workers as migrants fill the gaps between diminishing, or absent, public service provision and families' needs (Shutes and Chiatti, 2012; Van Hooren et al., 2018).

The expanded role of private for-profit providers, particularly, also has ramifications for the quality of services provided to older people. A systematic review of evidence in this area found lower levels of staffing and a lower quality of care in for-profit nursing homes as compared to not-for-profit homes (Comondore et al., 2009). More recent evidence confirms that for-profit providers are associated with a lower quality of care, poorer working conditions, lower pay and the expansion of predatory financial practices in the sector (Corlett Walker et al., 2022). US research has also found major deficiencies in the largest for-profit nursing home chains (Harrington et al., 2011; Americans for Financial Reform Education Fund, 2020). How countries are organising the regulation, inspection and quality control of the sector remains a central challenge. Increasingly, there are alternative models emerging with

cooperatives and social enterprises aiming to deliver both higher wages and higher-quality care (see Box 3).

Box 3 Innovative delivery models

There are a number of innovative delivery models aimed at improving care work dynamics from the perspectives of both workers and care receivers. One example is care cooperatives (Button and Bedford, 2019). This is the most popular model of care provision in Bologna, Italy, accounting for 85% of the city's care services (Walljasper, 2017) – including for older persons – while keeping costs lower and outcomes superior to both state- and corporate-provided alternatives (Restakis, 2007). In Japan, a federation of health and welfare cooperatives operates 28 nursing homes, as well as 75 hospitals and 337 primary healthcare centres (Japanese Health and Welfare Co-operative Federation, n.d.).

In the UK, the Equal Care Co-op offers an example of a democratically owned and governed cooperative, established with the objective of distributing power more fairly between workers, those receiving care and care receivers' families. It uses an online platform to facilitate direct connections between care workers and those in need of care, circumventing the higher overhead and management costs associated with large companies. Due to cost-saving, the cooperative's workers receive wages that are 25% above the industry average, while prices are maintained at market rates (Stanley et al., 2021). One of the newest examples of cooperative-provided care comes from Ireland, where Maria Jikjela, from South Africa, has founded the Great Care Co-op. The workers providing care services through the cooperative come from Uganda, Zimbabwe, the Philippines and South Africa, all of whom came together through the Migrant Rights Centre of Ireland (Holland, 2020).

In the Netherlands, Buurtzorg Nederland, a not-for-profit company, employs more than 8,000 care workers, organised in self-managed teams and caring for about 65,000 patients annually. The model has been praised for delivering quality care with lower overhead costs and employee turnover, motivating efforts in Norway, Sweden, the US and elsewhere to adapt it to their country contexts (Gray et al., 2015).

Another innovative delivery model is that of social micro-enterprises, which typically employ no more than five people, and prioritise higher wages and the provision of high-quality care over profit generation. Beginning in 2014, Community Catalysts CIC, a UK-based social enterprise working in collaboration with Somerset Council, created 867 care-focused micro-enterprises. The Somerset Micro-enterprise programme, now managed solely by the Council, provides approximately 6,000 people with support, having created 728 new jobs. A 2020 study surveying a sample of 125 micro-providers showed that this model saved £2.9 million a year while improving outcomes: those receiving care reported that the support they received was more consistent, reliable and personally focused than traditional models (DHSC, 2021c).

Increasing private equity involvement in the older persons' care sector is also a reality in some countries. In the UK, private equity and investment fund acquisitions of providers have become common and many of the largest care sector companies have complex corporate structures, with numerous subsidiaries registered in tax havens (Stanley et al., 2021). Practices of cash extraction and the frequent buying and selling of chains, often using debt-leveraged buyouts, have left some burdened with debt (with some even collapsing), leading to growing concern about the financial stability of large care providers (Burns et al., 2016; Blakeley and Quilter-Pinner, 2019). In the US, increasing private equity ownership of care facilities has also been noted, with private equity ownership of nursing homes associated with reduced staffing levels, a lower quality of care and increased short-term mortality, alongside increased taxpayer spending (Gupta et al., 2021).³ The impact of excessive financialisation of the care sector in the US was also highlighted during the pandemic, with a study documenting higher infection rates and higher fatality rates from Covid-19 in private equity-owned nursing homes compared to other facilities (Americans for Financial Report Education Fund, 2020). Both studies highlight the fact that private equity ownership is associated with lower staffing levels; these levels are assessed as being a key driver of poorer health outcomes.

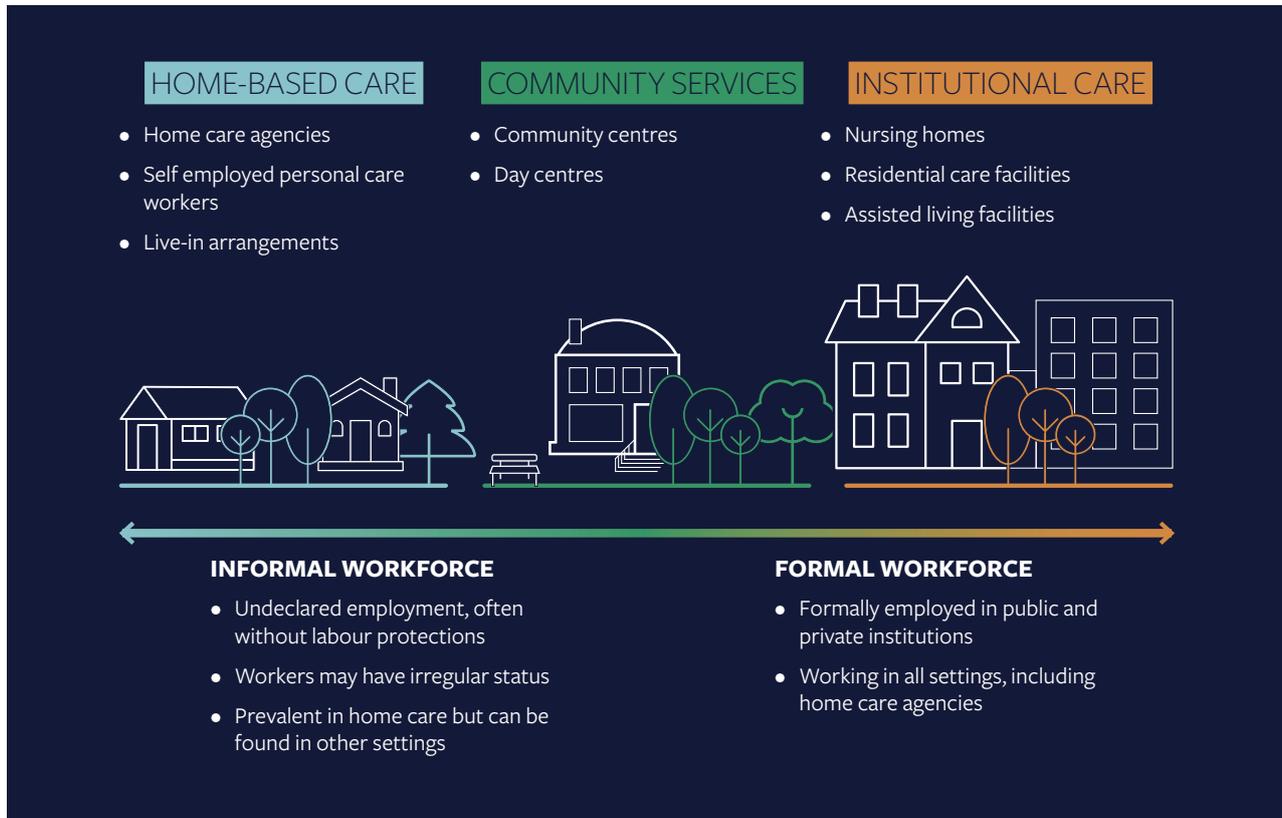
Though less well-studied, the increasing private equity acquisitions of care facilities for older people – mainly displacing traditional not-for-profit care providers – has also been documented in Australia (Grant Thornton, 2015). Investors have been attracted by high growth forecasts given the

country's rapidly ageing population and increasing care requirements, as well as government reforms. These have given operators greater flexibility to set fees and new opportunities to generate income (ibid.). In addition, private equity ownership of care facilities looks set to expand beyond the US, the UK and Australia, with recent acquisitions in Japan, France, Switzerland, Germany and Ireland (UNI Global Union, 2020).

2.3.4 Towards home-based care and 'cash-for-care' models

Many countries (including the Netherlands, Sweden, the UK, Australia and Canada, among others) are moving away from providing institutional care to more home-based care options (Hussein and Manthorpe, 2005; Cangiano, 2014; OECD, 2020; OECD, 2021). This has been driven somewhat by a desire to reduce costs, but also by the preferences of older adults who wish to remain in their homes. In the Netherlands, for example, older people are enabled to live at home for as long as possible, with publicly funded services to facilitate this and support encouraged from unpaid carers as part of a 'participation society' (Bruquetas-Callejo, 2020: 106). This trend brings its own challenges, since home care is often less regulated, more informal, and noted for having more precarious work patterns and worse pay and conditions (ILO, 2018) (see Figure 3 for an overview of care settings and workforce aspects). The trend also reinforces the role of the family in supporting older people, reflecting enduring cultural norms related to the deep importance of familial care (Peng and Yeandle, 2017).

³ For more understanding of operating costs and the financial strategies used by private equity firms to create value, see Gupta et al. (2021).

Figure 3 An overview of older persons' care

'Cash-for-care' schemes have often accompanied the trend towards home-based care, as countries seek to find ways to respond to rapidly increasing care needs without resorting to residential care (Da Roit and Le Bihan, 2010; Bruquetas-Callejo, 2020). These schemes provide allowances to individuals to arrange their own care instead of relying on direct service provision. In Sweden, the Netherlands and the UK, cash-for-care schemes are one approach among the broader services on offer (Da Roit and Le Bihan, 2010; Peng and Yeandle, 2017). However, countries such as Italy, Spain, Austria and Germany have systems heavily based around cash benefits. In Italy, for example, cash allowances are the main feature of the public long-term care system, with many families relying on their 'attendance allowance' to access care mainly from migrant workers known as badanti (Gori, 2012; King-Dejardin, 2019). The high reliance on these monetary transfers and

low level of formal public service provision has resulted in a crowding-out of formal care services (Di Rosa et al., 2021). It is clear that the informal home-care arrangements, accompanied by a significant presence of migrant workers, can make services more affordable to those who might not otherwise afford care – as has been observed in Ireland and Italy (MRCI, 2015; King-Dejardin, 2019).

While supporting families to access care, and enabling older people to remain in their homes, these schemes have also resulted in high levels of informal employment – given that there are no checks on how individuals and families use this money to contract care – as well as creating a high dependence on migrant workers (Van Hooren, 2020). Households are also playing more significant roles in directly contracting and supervising private care services. This has turned families into employers of low-wage care workers

and extends marketisation trends further (Shutes and Chiatti, 2012). It is notable that under these schemes, governments have little control over the quality of services and the quality of employment (Di Rosa et al., 2012; Van Hooren et al., 2018), and they are generally associated with reduced labour protections and trends towards informality and irregularity (King-Dejardin, 2019).

2.4 The long-term care workforce

2.4.1 Overview of the current workforce

OECD data shows that most long-term care workers are women (on average 90%) and are middle-aged (the median age is 45) (OECD, 2021). There is evidence that younger women are more attracted to sectors with a ‘better image than long-term care’, such as childcare or hospital care (OECD, 2020: 43). More than 20% of the long-term care workforce across the OECD is foreign-born. There is a much higher reliance on migrants in many countries and particularly in home-care settings (OECD, 2020). In addition, almost half (45%) of care workers work part-time, often involuntarily, which represents more than twice the average share for part-time work across OECD economies (ibid.).

The coverage of older persons’ care needs that is achieved with the care workforce is highly variable across countries. In a survey of 32 OECD countries, there were on average 5.2 long-term care workers per 100 people aged 65 or over (OECD, 2021). Many countries fall below the threshold used by the ILO (2017) for adequacy of service delivery (4.2 long-term care workers per 100 people aged 65 or over). These include Ireland, the Czech Republic, Italy and Canada (see Figure 4). Although overall numbers of long-term care workers are increasing, in the context of ageing populations, progress is far from what

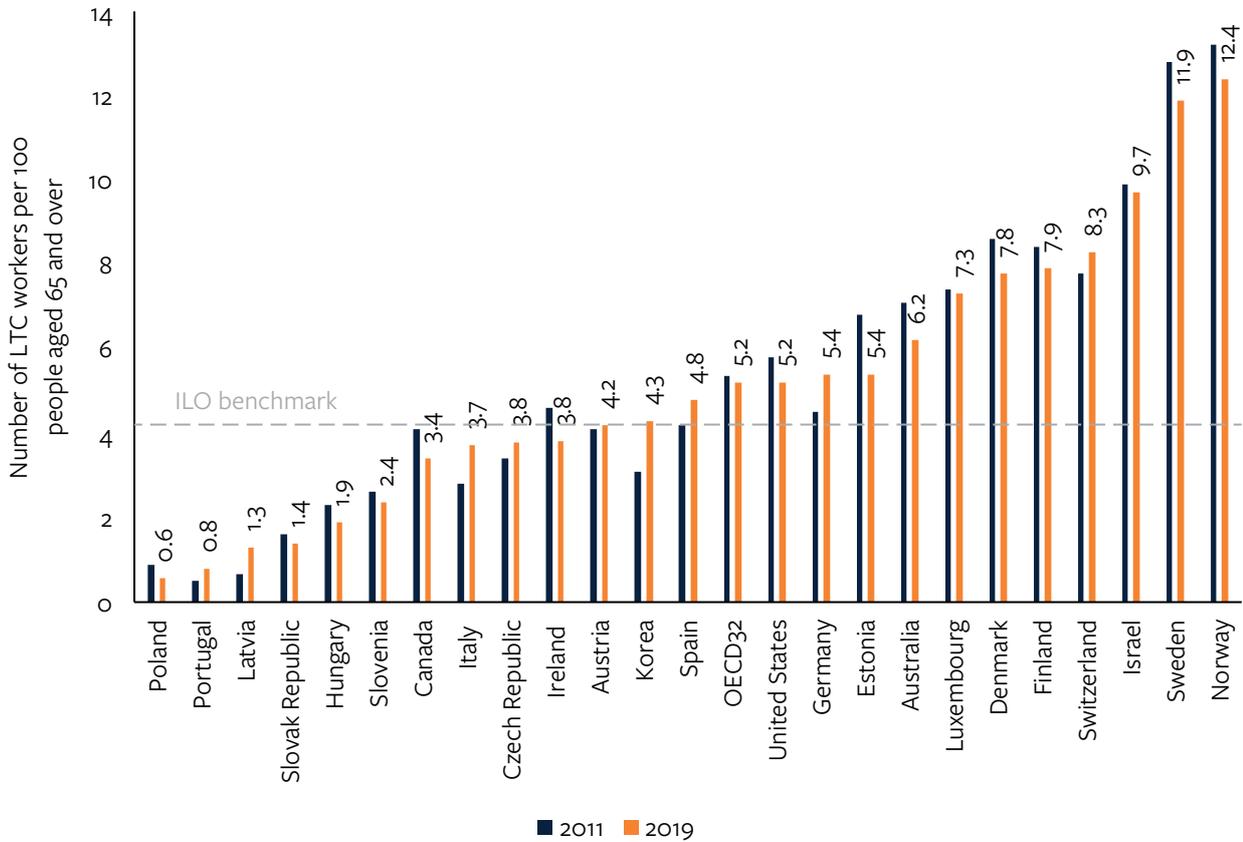
is needed: in more than half of OECD countries, population ageing has outpaced the growth of the long-term care workforce (OECD, 2021). For those countries that have been able to expand their workforce in the context of population growth, progress is minor, with countries generally adding at best about one long-term care worker per 100 people aged 65 or older in the population (see Figure 4).

2.4.2 Workforce shortages

Workforce shortages in the older persons’ care sector are not new. Two decades ago, studies highlighted serious challenges posed by, for example, high vacancy rates and difficulties with recruitment and retention documented in the US and in the UK (see discussion of earlier studies and surveys in Hussein and Manthorpe, 2005). The scale of current workforce shortages in the care sector is significant. For example, Australia’s recent care workforce survey records 22,000 vacancies across the sector – a vacancy rate of 5% (Australian Government Department of Health, 2021). In Japan, the Ministry of Health, Labour and Welfare predicted a shortage of 337,000 care workers by 2025 (Wright, 2019). The case studies in this paper present data on the scale of workforce challenges in China, the UK and the US.

Workforce shortages will become even more of a concern as populations age and the demand for care rises. Keeping the current ratio of long-term care workers to people aged 65 and older across OECD countries would mean increasing the number of workers in the sector by 13.5 million by 2040, an increase of 60% over 2016 levels (OECD, 2020). Very large increases in the workforce, of 80% or more, would be necessary in countries such as the Republic of Korea, Luxembourg, Ireland, France, Canada and Australia (ibid.). The necessary staffing increases that are forecast

Figure 4 Long-term care workers per 100 people aged 65 and over, 2011–2019



Note: The labels on the graphic refer to the number of long-term care workers per 100 people aged 65 and over recorded in the later year. Some OECD countries are excluded due to missing data or a break in the time series (e.g. France, the Netherlands, Japan and New Zealand). Most data is from 2011 and 2019 with some exceptions: Australia’s data is from 2012 and 2016; Denmark’s latest data is from 2018; Portugal’s early data is from 2012. Data from Sweden only covers public providers. The benchmark showing 4.2 long-term care workers per 100 people aged 65 and over refers to the ILO’s (2017) benchmark for adequate service delivery.

Source: OECD, 2021

are often significantly larger than those required for health workforces (Norden, 2014; Rocks et al., 2021).

2.4.3 The drivers of workforce shortages

The shortages experienced in the sector are largely the result of the unattractive and undervalued nature of care work, as well as demographic trends and increasing demand. The realm of care work also reflects poignant realities of intersectional discrimination, as it is typically women of colour, and often women migrating

from lower-income countries to higher-income ones, who perform a significant proportion of care within and outside of households, whether as domestic workers or personal care assistants to older people or those living with disabilities (Twigg, 2000). This has directly contributed to a general characterisation of caregiving as a ‘low-status migrant job’ (Cangiano, 2014: 147).

The general prevalence of low wages, poor working conditions and limited training and career advancement opportunities has also long been linked to high turnover and difficulties in

recruitment (Hussein and Manthorpe, 2005). These remain topical issues. The OECD's extensive (2020) study links turnover and recruitment challenges to: dissatisfaction with pay and career prospects; shift, part-time or temporary work; and lack of access to social protection and employment benefits, as well as other issues such as high exposure to physical and mental risk factors, low support and limited autonomy.

There has been a pervasive and long-standing characterisation of the sector as 'low-skilled', since care work is mainly associated with basic tasks such as washing, dressing and feeding – although evidence would suggest this is not an accurate description.⁴ A stakeholder review in the UK highlighted that care workers need strong interpersonal skills (empathy and emotional intelligence), the right ethics and disposition 'in order to provide highly intimate care for people with complex health and social care needs', in addition to nursing and technical skills (e.g. related to managing a complex medication regimen and a tracheostomy, stoma or catheter) (MAC, 2020b: 142). Caregiving activities also require higher competencies if older people have severe conditions. The OECD (2020) finds that in more than two-thirds of OECD countries, personal care workers' tasks go well beyond daily living activities and include: monitoring health conditions; providing psychological support; participating in the implementation of care plans; communicating with families and professionals; and case management tasks (OECD, 2020). Care workers

also support those who are receiving palliative care. In Scotland, a recent independent review of the sector recommended a national job evaluation programme to establish the true value of skills, competencies and responsibilities of carers, to properly benchmark workers against other health sector occupations (Scottish Government, 2021c).

Generally, care workers receive around the minimum wage in OECD countries (OECD, 2020). Wages are low when compared to other occupations that require similar levels of skills and training (Razavi, 2007), and also compare poorly to similar occupations in the health sector. The OECD (2020) finds, for example, that long-term care workers earn 35% less than those working in similar occupations in hospitals, and have more limited career prospects. New, more precarious forms of employment are also a challenge. The UK stands out for its high share of workers on zero-hour contracts;⁵ France for its use of temporary agency workers; and the Netherlands and the US for excluding domestic and personal care workers (often self-employed) from social and employment protections (OECD, 2020). Problems with unpaid working time are also an issue of concern, particularly the lack of compensation for travel time of home-care workers, a situation described as 'pervasive' by the ILO (2018: 180). Generally, the experience of care workers who provide direct care in home settings is notable for low wages, often dire working conditions and the likelihood of being exposed to discriminatory practices (ILO, 2018). Given that the care sector

4 Though classifications of migrants' skill levels are commonplace, classifying people as 'low-', 'medium-', or 'high-skill' is problematic and unhelpful. Traditional ranking systems align with patriarchal ideologies, privileging 'technical skills' predominant in fields dominated by men and undervaluing skills in sectors where women predominate, including the care sector. For more, see Cepla and Dempster, 2021.

5 Zero-hour contracts are contracts with no guaranteed hours. The ILO reports that such contracts typically imply unpredictable and insufficient hours of work, reduced earnings and diminished employment protection, as well as distinctive characteristics in relation to home care, such as remuneration that is restricted to the time when care workers are in direct contact with service users (ILO, 2018).

is increasingly a major employer, its low pay has large implications for women's position overall in the labour market. The Covid-19 pandemic has also significantly impacted on the conditions experienced within the sector, both for locals and migrant workers (see Box 4).

The undervaluation and under-regulation of care work has consequences for those individuals receiving care. Conditions for care workers have been directly linked to conditions for care recipients, with low pay, overwork and difficult working conditions associated with low-quality care (ILO, 2018). This is particularly important because quality care provision is dependent on personal relationships between caregivers and those receiving care, allowing for a genuine connection (Himmelweit, 2005). The potential for this connection can be sacrificed when caregivers are overworked and underpaid or are stretched too thin for their own mental and emotional well-being – which affects their ability to provide high-quality care. There is a broad consensus, therefore, that both care workers

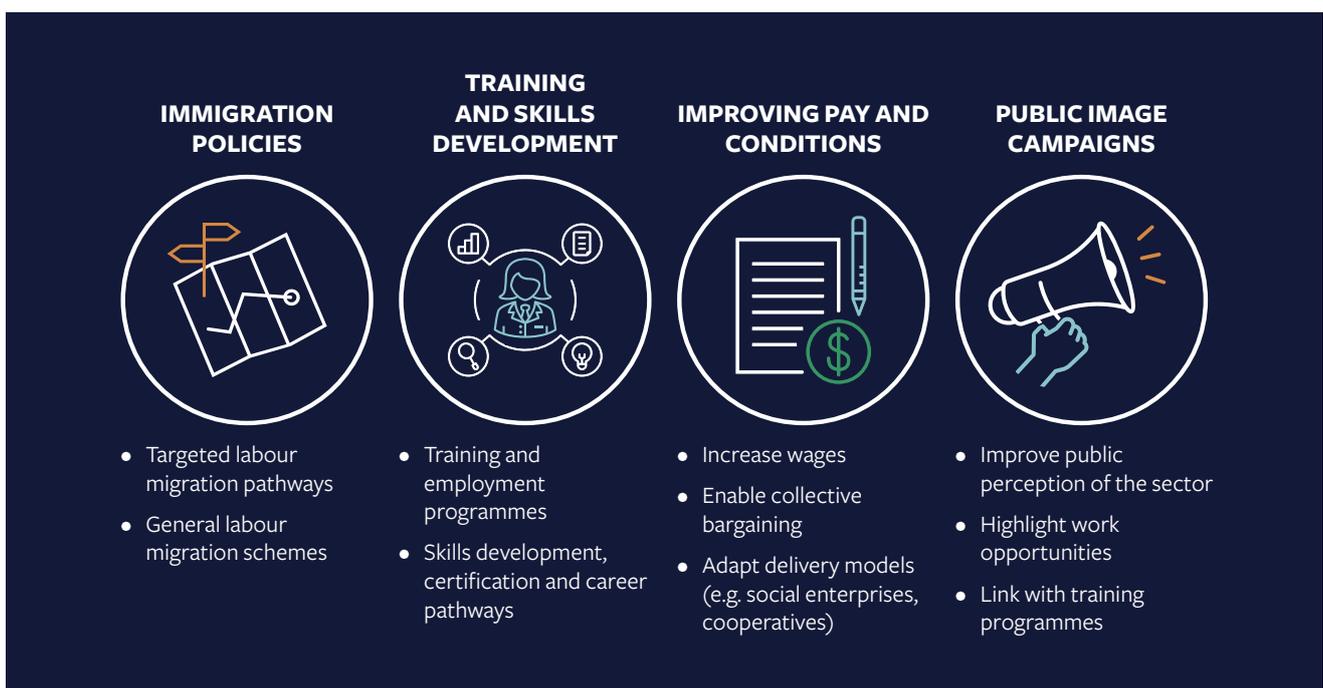
and care recipients would benefit from improved employment conditions in care work (Razavi and Staab, 2010; ILO, 2018).

Unsurprisingly in this context, the pay and working conditions of carers have become increasingly contested policy issues. A consensus has emerged around the need to promote a 'high road' for paid care provision (Folbre, 2006a; Razavi, 2007; ILO, 2018). While the 'low road' implies lower cost, higher labour turnover and lower quality, the 'high road' implies higher cost, effort and quality (Folbre, 2006a). The ILO (2018) has taken up the 'high road' agenda and offers a roadmap for achieving decent work for care workers and delivering quality services.

2.4.4 Responses to workforce shortages

Governments in high-income countries have been pursuing a mix of strategies to address the substantial workforce challenges facing the older persons' care sector (see Figure 5 for an overview). These include specific recruitment

Figure 5 Policy responses to workforce shortages



Box 4 Covid-19 and the older persons' care sector

Covid-19 has shone a spotlight on the older persons' care sector. The pandemic disproportionately affected older people, with up to 50% of deaths occurring within long-term care facilities (OECD, 2020). The older persons' care sectors in some countries were extremely hard hit, with more than 80% of all Covid-19 deaths occurring in long-term care facilities in Canada and 66% in Spain in the early stages of the pandemic (Canadian Institute for Health Information, 2020).

Care-home workers have been at the forefront of the pandemic response, facing significant personal risks and working in high stress environments. Many struggled to obtain personal protective equipment as the care sector was often a lower priority than the health sector in many locations (ILO, 2020a). As a result, long-term care workers were exposed to higher infection risks than other workers (Rocard et al., 2021). Notably high rates of illness and death of long-term care workers have also been documented (see ONS, 2021a and 2021b for UK evidence and Rocard et al., 2021 for a cross-country overview).

The pandemic also took its toll on long-term care workers in other ways. Due to infection risks, some workers changed to live-in work arrangements, leading to overwork in some instances (Van Hooren, 2020). In the UK, the increased workload and risk of 'burnout' is now a major concern for employers (Skills for Care, 2021). While countries such as Canada, Scotland, Wales and Australia introduced bonuses and top-ups in recognition of the risks to care workers during the pandemic, these were generally temporary and provided only marginal pay increases, doing little to address substantial pay challenges (Reed et al., forthcoming).

Poor workforce conditions have had multiple ramifications for the effectiveness of countries' pandemic responses. Low wages, lack of full-time employment and lack of access to sick leave meant that many care-home workers continued to work while sick, including in multiple facilities, ultimately spreading the virus further (ILO, 2020a). By contrast the presence of unions was associated with lower infection rates among nursing home residents and lower mortality rates from Covid-19 (UNI Global Union, 2020). These findings were explained by unions demanding more robust standards of health and safety and better infection control measures, as well as the existence of benefits such as paid sick leave, which underlines the importance of unionisation and collective bargaining for the sector.

In countries where migrants provided the majority of care, special policies had to be enacted to ensure continuity of provision. For example, Austria lifted travel restrictions and organised special transport to bring in migrant care workers, and Italy enacted a special temporary regularisation of domestic and care workers (Van Hooren, 2020). All this has served to make policy-makers and the public more aware of the issues inherent within the older persons' care sector, particularly calling into question the resilience of a system that relies so heavily on precarious and irregular work (ibid.).

drives, as well as efforts to improve pay, working conditions and career advancement to tackle high turnover rates and to make care jobs more attractive to new entrants. Earlier research has suggested that improvements need to be made to the entire job package – including pay, career advancement prospects and the sector’s image – to bring about higher recruitment and retention (Hussein and Manthorpe, 2005).

OECD (2020) analysis suggests that more comprehensive efforts – which include education, training and employment – deliver the best results. For example, the Norwegian government’s Men in Health recruitment and training programme, which targeted unemployed men and provided eight weeks of guided training to become paid carers, is considered very effective. In addition, Japan’s very successful programme targeting middle-aged and older workers, and supporting their training and entry into care jobs, helped to expand the care workforce by 320,000 workers between 2011 and 2015 (ibid.).

Alongside such programmes, many recruitment drives also include campaigns to improve the perception of the sector. Public image campaigns have a long history of implementation (Hussein and Manthorpe, 2005) and have in recent years been actively pursued in many countries (including France, Australia, Belgium, the UK, Czech Republic and the Netherlands). However, their impacts are less clear (Colombo et al., 2011; OECD, 2020).

Prior research has established that wages and benefits in the long-term care sector generally influence recruitment and retention. In addition, changes in minimum wages (access and thresholds) are seen as an effective way of increasing care workers’ pay (Vadean and Allan, 2017). However, evidence from the UK shows

clearly that small increases in hourly rates of pay do not substantially affect worker turnover and only once care workers are paid significantly above the national minimum wage is an impact on turnover rates recorded (Skills for Care, 2021). In the past decade, more than half of OECD countries have sought to increase wages, with some countries achieving more success than others. Both Hungary and the Czech Republic increased wages for care workers substantially, with the Czech Republic reforms credited with stabilising the workforce at around 100,000 people (OECD, 2020). Austria’s successful implementation of collective agreements is also notable. However, some countries’ strategies have had mixed results and the OECD (2020) cautions that wage policies can lead to more precarious employment, reduced hours or increased workloads if not always accompanied by sufficient public funding to support the measures taken. Overall, it is clear that the degree of collective bargaining and unionisation achieved in the sector is very important for achieving higher wages, better working conditions and labour protections (Folbre, 2006a; ILO, 2018; OECD, 2020). However, experiences of social dialogue are uneven across OECD countries and rates of unionisation are low (OECD, 2020).

There is also the option of increasing productivity and efficiency, including through an increased reliance on technology, as part of a strategy to address skills shortages and to control rising wage costs in this labour-intensive sector. However, there is a well-known tension between increasing productivity and maintaining care quality, given the limits to the number of older adults whom one person can care for (Razavi, 2007; ILO, 2018). Productivity enhancements often translate to reducing the time spent with each older person, leaving little room for personalised interaction, and directly affecting the quality of care (Razavi

Box 5 The use of robotics in the older persons' care sector in Japan

Japan has actively integrated robotics into its older persons' care sector strategies since 2003 (ILO, 2018). The strategies aim not to reduce the overall amount of human-to-human care, but instead to use robotics to reduce the burden of care work (and as such lessen care worker turnover), to enhance efficiency and productivity, as well as to help older people live independently for longer in their own homes (METI, 2015). The prioritised technologies profiled in the country's strategies are transfer aids, mobility aids, toilet aids, monitoring systems and bath aids (ibid).

Japan's heavy promotion of robotics is linked to the country being a world leader in these technologies and a desire to promote the domestic robotics industry (METI, 2015). A specific sales target around nursing care robots of 50 billion yen by 2020 (approximately \$440 million as of 8 December 2021) is included in the country's robotics strategy (ibid). Targets do not appear to be driven by demand. As of 2018 only 5% to 10% of care homes in Japan had care robots, with a smaller percentage estimated to be consistently using them (Wright, 2019). Also clear is that the preference for robotics has been influenced by Japan's historic anti-immigration stance, which has additionally motivated the use of robotics as a strategy to limit reliance on foreign-born care workers (French, 2003; ILO, 2018; Wright, 2019).

Some concerns have been expressed around the impacts of the use of robotics. Researchers have noted that they could have unintended consequences in terms of the quality of care and social interaction, in particular fostering loneliness (Folbre, 2006b; Parks, 2010). However, positive impacts have also been documented. Eggleston et al. (2021), in a large-scale analysis of facility-level data, found that monitoring technologies have helped to decrease the rate of physical accidents and that robotic aids have successfully reduced the physical burden on care workers.

The same study also found that robot adoption in nursing homes increases employment, but only of non-regular employees working under flexible employment contracts and without benefits (Eggleston et al., 2021). Nursing homes using robots reported less difficulty with staff retention, suggesting that the use of robotics may be a successful way to reduce the burden of care work. The number of regular workers was not affected, but monthly wages – particularly of registered nurses – were reduced, though this appeared to be mainly as a result of fewer night shift hours.

Their study also confirmed that the use of these technologies is fairly limited. While the use of monitoring aides was fairly common, only 5.3% of nursing homes in their survey were using mobility robots to help with movement, toileting and bathing, and only 2.8% were using robots to communicate and interact with patients. The fact that these technologies are unable to perform complex tasks and replace social interactions has likely influenced the limited take-up of robotic aids of this kind so far (Maibaum et al., 2021).

and Staab, 2010). Given the fundamental relational nature of care work, the potential substitution of technology for labour is seen as limited (ILO, 2018; OECD, 2020). It has really only been the subject of experimentation in Japan although it is also increasingly being considered in China (Wright, 2019; Yang et al., 2021; see Box 5). When preparing its forecasts of long-term care worker shortages, the ILO decided not to take into account labour-saving technological change at all on this basis (ILO, 2018).

As illustrated here, many countries are grappling with a variety of responses to workforce shortages and are pursuing specific strategies to make the older persons' care sector more attractive to the domestic workforce. At the same time, immigration is, for some, already a well-established, additional strategy to address workforce shortages. The employment of migrant workers, the extent of their contribution to the sector and the nature of their working conditions is explored in the next section, alongside profiles of countries that have developed specific immigration pathways and migration programmes to support recruitment into the older persons' care sector.

3 Migration for older persons' care

3.1 Patterns of migration: main countries of destination and origin

Many high-income countries are heavily reliant on migrant workers to staff their older persons' care workforce.⁶ Throughout the OECD, on average, more than 20% of the long-term care workforce is foreign-born (OECD, 2020). This is likely to be an understatement, as many OECD countries have very large informal and home-based care provision, which evidence suggests may involve even higher numbers of migrant workers (OECD, 2015). Some labour market surveys are able to investigate this population. For example, in 2012/13, of the care workers directly employed by households in 25 OECD countries, 28.5% on average were foreign-born (ibid.).⁷ The long-term care sector exhibits higher rates of reliance on foreign-born workers than other sectors in the majority of OECD countries, with some countries (e.g. Israel, Ireland and Canada) more reliant than others (Figure 6)

In some countries, this reliance has also been increasing over time. For example, between 2012/13 and 2020/21, there was a 12% increase in the number of non-British nationals working in the UK's care workforce (Skills for Care, 2021). In the US, between 2007 and 2017, the share of migrants in the direct care workforce increased from

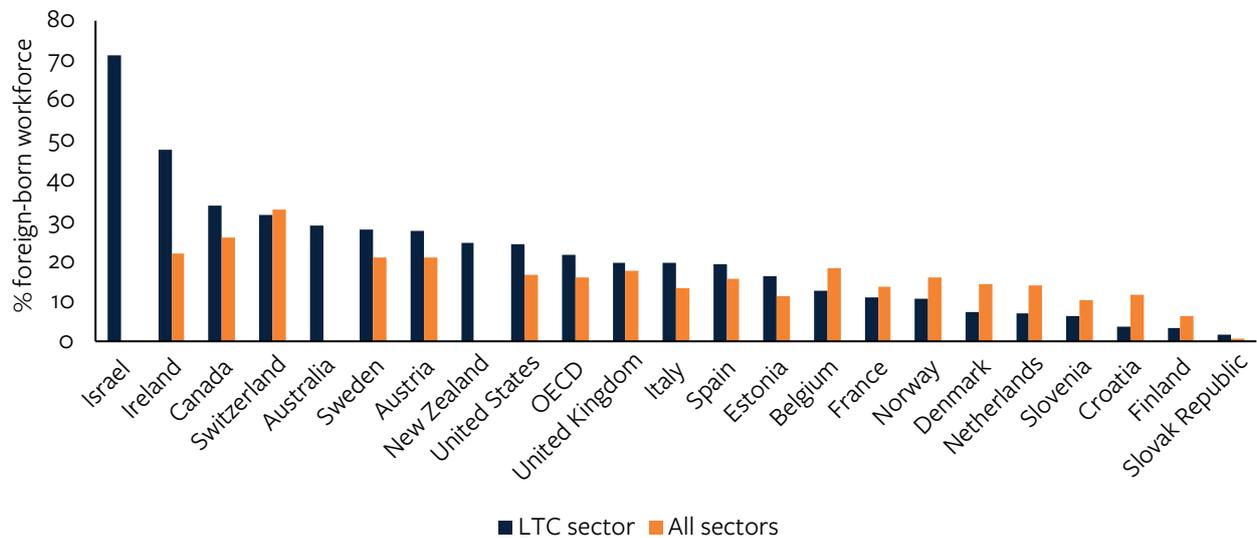
22% to 26% (Campbell et al., 2021). In Australia, the number of foreign-born staff hired to the residential care sector increased from 33.6% in 2007 to 39.9% in 2016 (Mavromaras et al., 2017). As will be described below, some countries have deliberately sought to increase the number of foreign-born workers in the sector by creating specific immigration policies and agreements to encourage such mobility. Other countries have received these increases passively, with migrants drawn to opportunities that are not attractive to locals due to poor wages and working conditions.

Older persons' care workers come from a large variety of countries of origin. The predominant countries of origin vis-à-vis a certain country of destination largely map to common migration routes, which are themselves determined by geographical proximity, historical links, language and other forms of migration flows (Spencer et al., 2010). For example, Van Hooren et al. (2018) outline how the origin of migrant workers depends on colonial legacies, with Eritreans migrating to Italy, Latin American migrants moving to Spain and those from former French colonies migrating to France. That being said, there are some countries of origin that have sought to 'specialise' in sending healthcare workers abroad, such as the Philippines (Abarcar and Theoharides, 2021).

6 This report will largely focus on the role of international migration in meeting the demand for older persons' care work. Certainly, in most countries, there is a long-standing pattern of rural to urban migration to meet this demand, often leading to a 'care drain' in those rural areas (see Box 7). This dynamic will be explored in more depth in the China case study.

7 Sweden, the UK, the Slovak Republic, the Netherlands, Italy, Finland, Switzerland, Belgium, the Czech Republic, Austria, Estonia, Norway, Spain, Hungary, Slovenia, Luxembourg, Poland, Greece, Portugal, Germany, Ireland, France, Canada, Israel and the US. Countries are ordered by decreasing importance of the share of older persons' carers in the labour force.

Figure 6 Share of foreign-born workers among the long-term care workforce in a selection of OECD countries



Note: The OECD data point is the unweighted average of the 21 OECD countries shown in the chart for which data is available about the long-term care sector and across all sectors. EU-Labour Force Survey data is based on ISCO 4-digit and NACE 2-digit codes. Other data is based on ISCO 3-digit and NACE 2-digit codes. Data must be interpreted with caution as sample sizes are small.

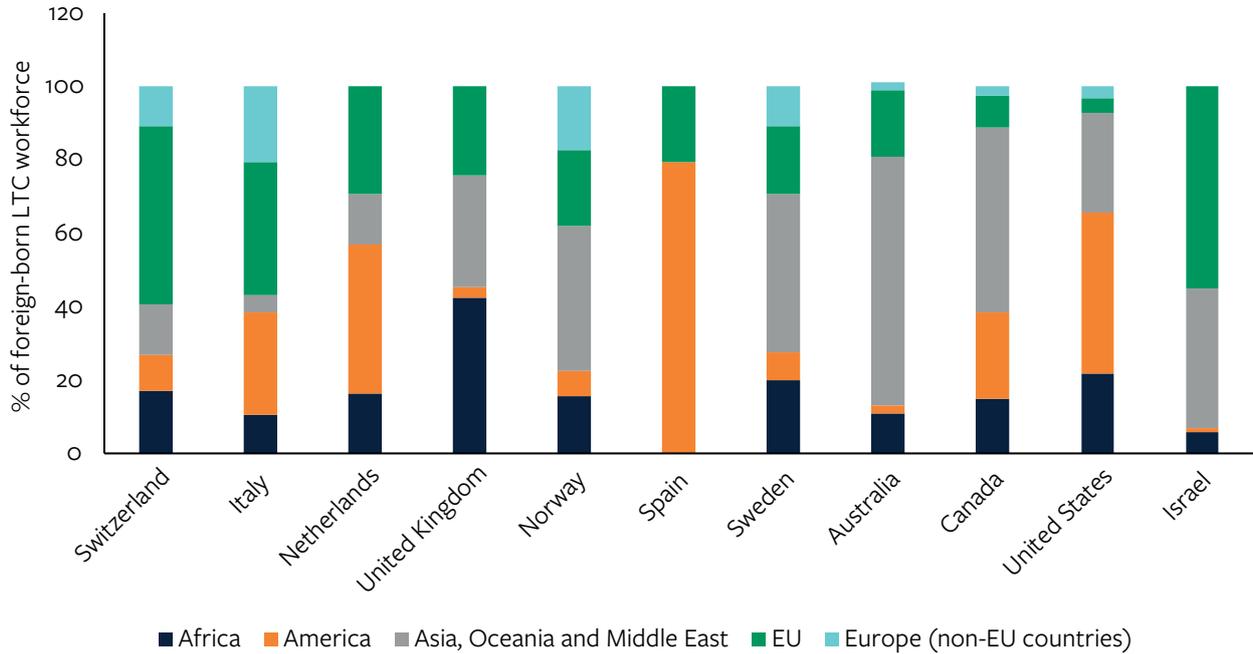
Source: OECD, 2020.

Figure 7 details the main patterns of migration for older persons' care. As is evident, different regions of the world 'supply' countries of destination at different rates. Primary countries of origin for North American countries like the US and Canada include the Caribbean countries, Mexico and the Philippines. The high-income countries of the European Union tend to rely on migrant workers from lower-income eastern European countries such as Romania, Poland and Bulgaria. Migrant workers from African countries, such as Nigeria, Kenya and Zimbabwe often end up in Commonwealth destination countries like the UK and Australia. Finally, high-income Asian countries like Japan, China and Singapore tend to attract workers from the Philippines as well as India, Indonesia and Vietnam.

The circumstances under which this migration takes place vary. Some migration occurs within free movement agreements, such as from eastern

to western Europe. As a result, people can be hired directly and locally without specific work permits. In some European migration corridors such movement is fluid, with workers operating in shifts and travelling back home regularly (Van Hooren, 2020). In the European context, an interesting form of chain migration also emerged. Workers from Ukraine and Belarus entered the informal care sector in Poland to replace Polish migrants who moved to Germany and the UK to work within the formal care sectors in those countries (Keryk, 2010; Lutz and Palenga-Mollenbeck, 2012). In several countries, however, the availability of older persons' care workers from EU Member States with lower income levels is not sufficient to plug workforce gaps. Against this background, in some cases, there is a discrepancy between the demand for older persons' care and the migration regulations for care workers. This has resulted in foreigners from outside the EU being employed illegally throughout Europe, producing

Figure 7 Regions of origin of foreign-born long-term care workers in selected countries



Note: Composition of the foreign-born long-term care workforce, by world region of birth, 2015 (or nearest year). Data must be interpreted with caution as sample sizes are small.

Source: OECD, 2020

a large undocumented workforce. In response, for example, Italy conducted three regularisation campaigns (in 2002, 2009 and 2012) specifically targeting the many undocumented domestic workers who were providing care (OECD, 2015).

Other countries have sought to actively encourage the migration of older persons’ care workers through provisions within their immigration systems, or through the negotiation of bilateral labour agreements (BLAs), memoranda of understanding (MoUs), and other forms of legal labour migration pathways. These pathways exhibit a range of different migration approaches. While some facilitate long-term or even permanent migration, the majority facilitate short-term and temporary visa access. Almost all OECD countries classify older persons’ care workers as ‘low-skilled’ migrants, with few offering a swift pathway to permanent residency (OECD, 2015).

Some countries, such as the Philippines, have deliberately positioned themselves as a primary country of origin for health and older persons’ care migration. The Philippines has developed sophisticated overseas employment agencies and diaspora liaison mechanisms to promote and support emigration of these workers abroad. It has also sought to develop BLAs and MoUs with specific countries of destination, seeking investments in their health system and training in return for facilitating the provision of workers (Makulec, 2014). There is evidence suggesting that the presence of migration opportunities can incentivise people to educate themselves within that skillset, whether they move or not. This can increase both human capital and the number of workers with a particular skill within the country of origin (Batista et al., 2012; Abarcar and Theoharides, 2021).

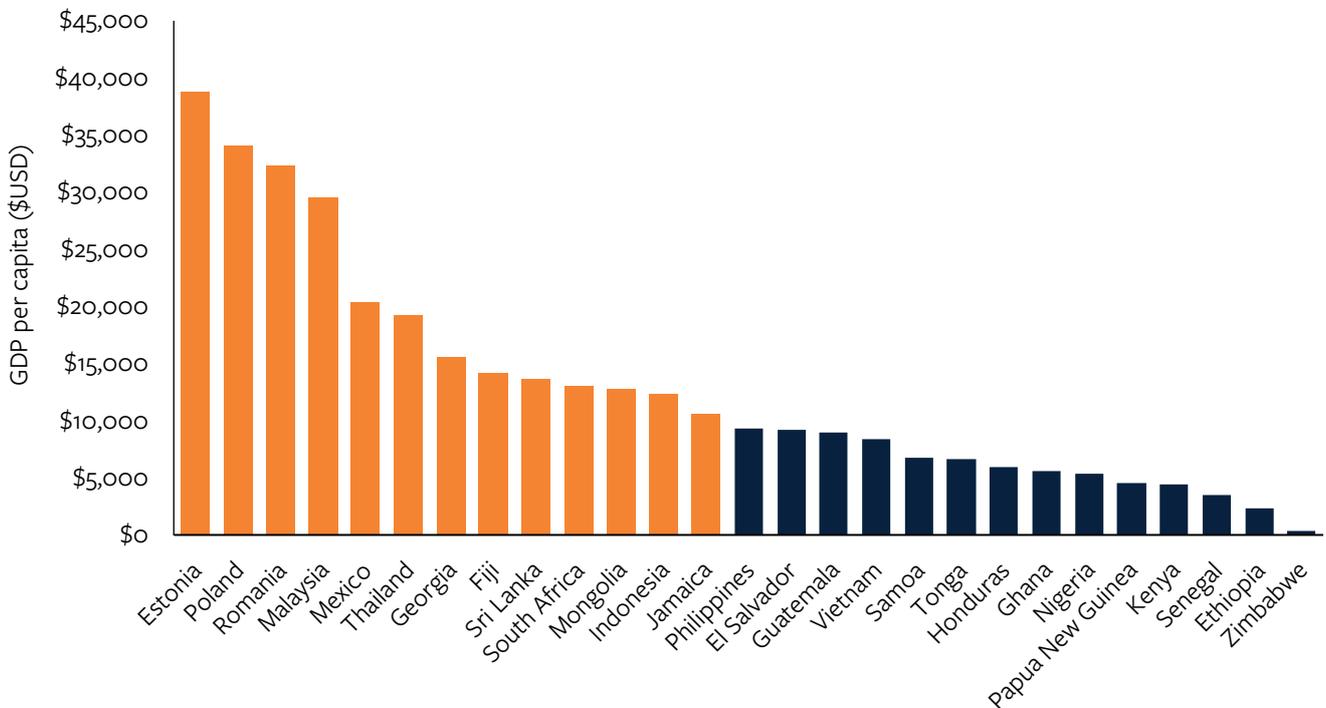
These migration patterns may shift in the future. For many high-income countries, rapidly ageing populations will create significant challenges, including increased demand for older persons' care workers and fewer working-age locals to meet this demand. Yet the countries of origin that have traditionally sourced these countries of destination are likely to change for two main reasons.

Firstly, there is a vast amount of literature that demonstrates a dynamic called the 'migration hump' (Clemens, 2020). As countries grow economically, more people are likely to move. This trend peaks and then reverses after a country reaches an income level of roughly \$10,000 gross domestic product (GDP) per capita (purchasing power parity (PPP)). There are many reasons for

this dynamic, but effectively large and increasingly skilled youth populations are unable to find work at home and have the resources and the motivation to seek work abroad. At the tipping point, more opportunities become available at home, reducing this pressure. As Figure 8 shows, almost half of the primary countries of migrant origin for older persons' care workers have already reached this tipping point, with others nearing it. As a result, we are likely to see a reduction in emigration pressure from these countries of origin in the future.

Secondly, these countries of origin are also, themselves, ageing. They will require their own older persons' care workforce in the decades to come. Many of these countries will far exceed the global average old-age dependency ratio forecast

Figure 8 GDP per capita (based on purchasing power parity) in select countries of migrant origin, 2019



Note: GDP per capita (PPP) data, retrieved 16 November 2021. The countries in blue fall below the estimated tipping point at which migration trends tend to reverse.

Source: World Bank (n.d.)

for 2070 (30.7) and are following similar trends to the countries where they are currently sending workers (UN DESA Population Division, 2019).⁸

Figures 9 and 10 show that countries of origin are tracking roughly 20 to 30 years behind their primary countries of destination. This suggests that countries of destination may have a limited amount of time from which to draw on this labour, before it is needed at home. As a result, it may be necessary for these countries to look elsewhere, to countries that are not yet providing older persons' care labour abroad.

3.2 The experience of migrant workers in the older persons' care sector

3.2.1 Skills

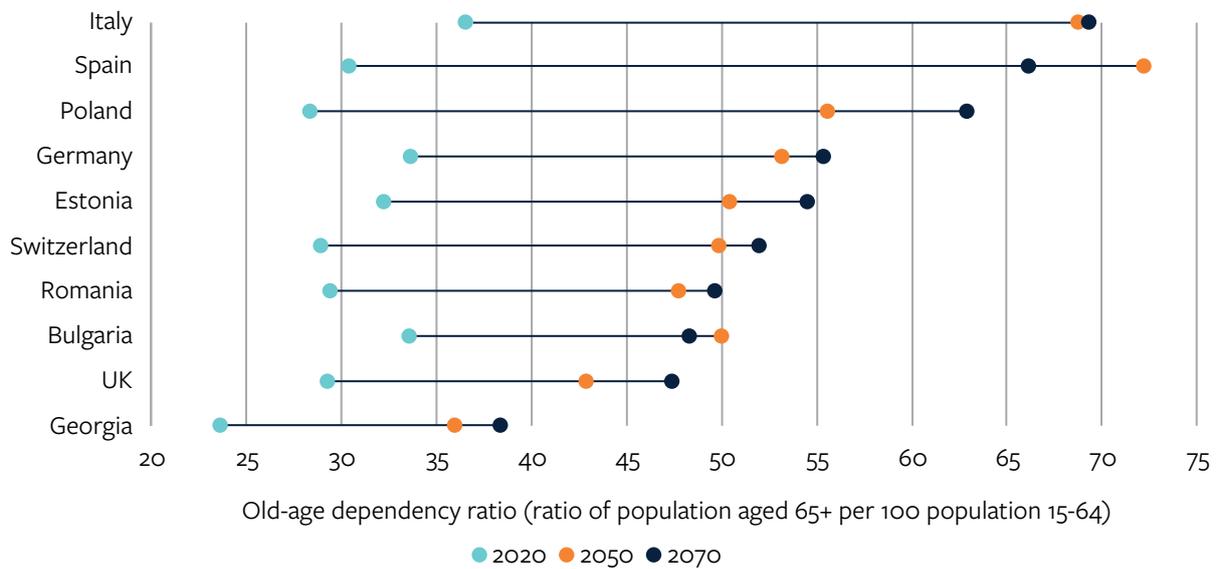
Older persons' care is routinely seen as a sector that requires a 'low' level of skills, and therefore one that attracts people with a lower level of schooling than others. For example, the OECD (2020) notes that long-term care workers generally have fewer formal educational qualifications than health workers overall. But this does not seem to be the case for the foreign-born workforce. Evidence suggests that most foreign-born long-term care workers are highly skilled, with many qualified as doctors, nurses and therapists in their country of origin (Hussein et al., 2010; King-Dejardin, 2019). For example, Figure 11 shows survey evidence (from an admittedly

small sample) showing that migrants in the long-term care sector are more likely to report being overqualified for their job than women in other sectors. Many hold higher degrees than are required for care work. For example, in Australia, around one-third of migrant health and social care workers were operating at a lower skill level than they had in their country of origin (Pillinger, 2012).

Many migrant older persons' care workers therefore operate in their country of destination at a lower level than the one they are qualified for, largely because they are unable to get their qualifications recognised in their country of destination (Global Ageing Network and LeadingAge LTSS Center @UMass Boston, 2018). For example, in Singapore, many nurses are unable to obtain certification from the Nursing Board, resorting to operating with a foreign domestic worker work permit instead. In Australia, qualified nurses and midwives were working as 'assistants' because their qualifications were not recognised (King-Dejardin, 2019). This demonstrates the necessity of promoting qualification and skill recognition for migrant workers, to ensure that they can fully contribute to their country of destination. It also points to the need to integrate some form of qualification and skill harmonisation into migration agreements. However, migrants do often struggle with some skills, particularly knowledge of the local language and culture (Christensen et al., 2016 ; Tinarwo, 2017; Sahraoui, 2019).

8 The old-age dependency ratio is the ratio between the number of older people to younger people. Specifically, it is the number of older people (aged 65+) per 100 people of working age (aged 20 to 64). It measures the impact of an ageing population, as it shows the reliance on younger people for both workforce and pension needs. However, this model has its limitations, as it fails to consider that many people aged 65+ (disproportionately women) continue to perform both paid and unpaid work, due both to health advances that facilitate freedom and limited social safety nets that constrain it. Alternative models have been proposed (such as the prospective old-age dependency ratios, see Scherbov and Sanderson (2020)), but widespread adoption is pending.

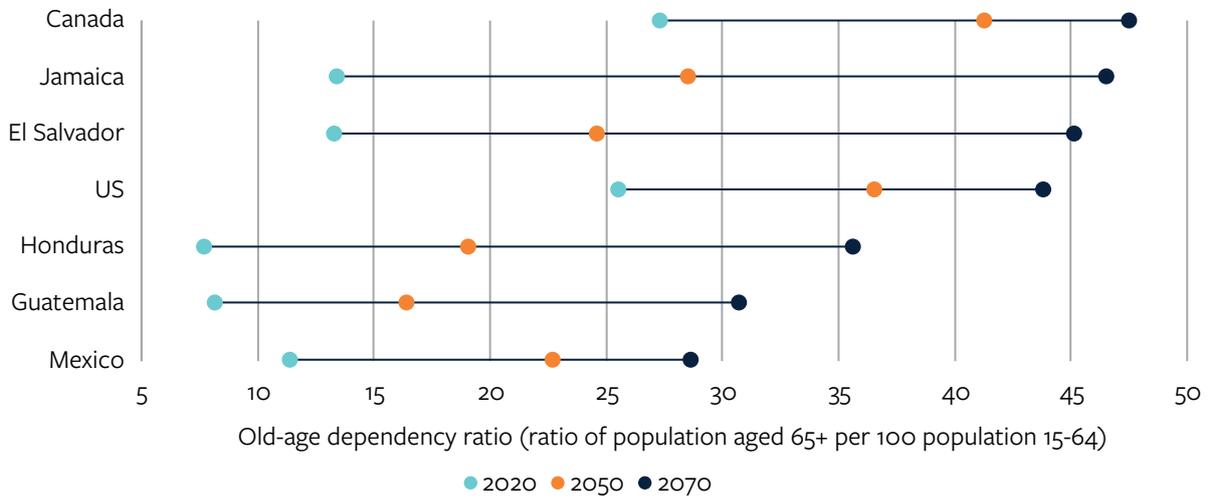
Figure 9 Ageing trends in a selection of countries of origin and destination in Europe, 2020–2070



Note: This figure uses UN DESA ‘medium variant’ projections.

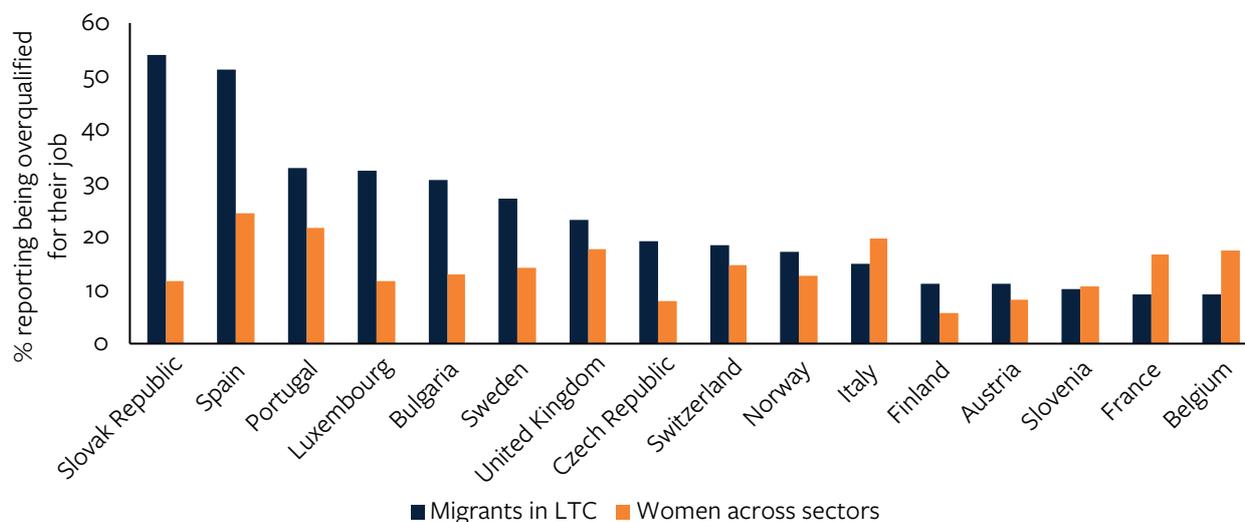
Source: UN DESA Population Division, 2019

Figure 10 Ageing trends in a selection of countries of origin and destination in North and Central America and the Caribbean, 2020–2070



Note: This figure uses UN DESA ‘medium variant’ projections.

Source: UN DESA Population Division, 2019

Figure 11 The overqualification of foreign-born workers in the long-term care sector, 2013

Note: EU-Labour Force Survey data was calculated based on ISCO 3-digit and NACE 2-digit codes. Data must be interpreted with caution as sample sizes are small.

Source: OECD, 2020

3.2.2 Work setting

The demand for migrant labour is pervasive across the entire care sector, ‘from familialist care regimes to public services and market-led regimes, and in different institutional contexts, from private households to private residential care homes and private home-care agencies’ (King-Dejardin, 2019: 103). That being said, migrant workers have traditionally been prevalent within certain delivery models, especially home-based care; a country of destination’s reliance on a certain delivery model will therefore largely dictate their reliance on migrant workers. Yet data is limited, making it difficult to compare the prevalence of migrant workers in different informal and formal settings.

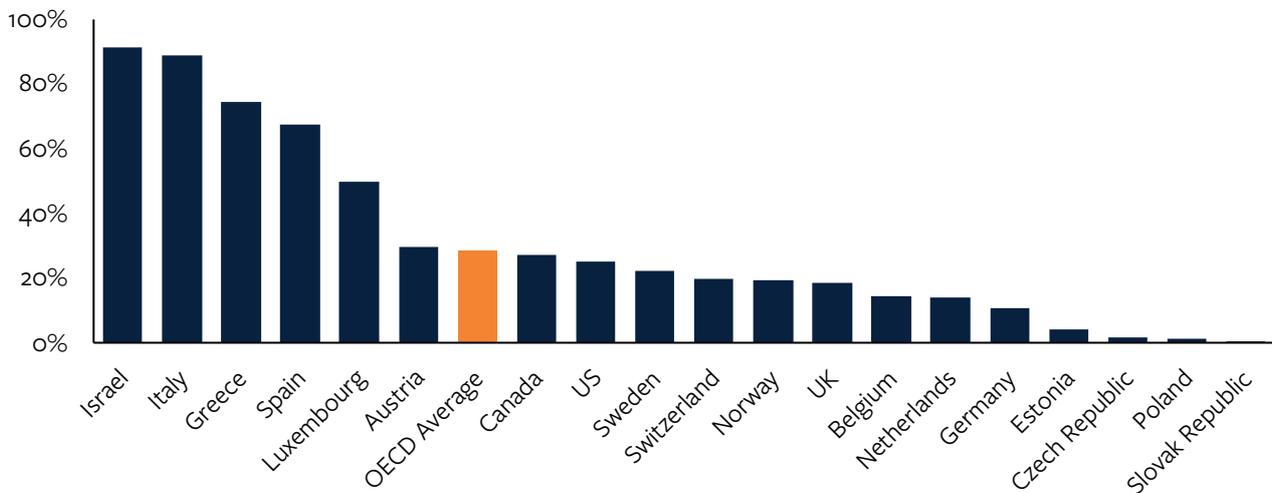
The limited data provided by the OECD (2020) shows that, in some European countries, the share of foreign-born workers is greater among institution-based care providers than among home-based providers. A similar trend can be seen in Australia, where 32% of institution-based workers are migrants versus 23% among home-

based workers (Mavromaras et al., 2017). In other countries, such as Israel, Greece and Spain there is a higher prevalence of migrant workers in home-based care settings (OECD, 2015; Da Roit and Van Bochove, 2015; see Figure 12). For example, several studies have estimated that 89% to 90% of older persons’ care workers in Italy were foreign nationals (Pasquinelli and Rusmini, 2013; OECD, 2015).

These trends may differ depending on whether the care is publicly or privately delivered. On the whole, public employers tend to offer better wages and working conditions, thereby attracting more local workers – though there are fewer of these jobs available. Private employers tend to offer lower wages and poorer working conditions, and hence migrant workers may predominate (Spencer et al., 2010; Cangiano, 2014).

3.2.3 Wages and working conditions

The majority of the literature shows that migrant workers in the older persons’ care sector are

Figure 12 Foreign-born workers in OECD home-based care systems, 2013

Source: OECD, 2015

more likely than local workers to encounter sub-standard wages and working conditions, including working part-time, long hours, night shifts, and being paid less for the same work (Van Hooren, 2012). For example, the ILO (2018) shows that in Germany, migrant workers from other EU countries are often supplied through agencies abroad and are put onto temporary (up to 24 months) and ‘24-hour’ contracts. Surveys conducted by the Migrant Rights Centre in Ireland with migrant workers employed in private households and in nursing homes, found that almost a quarter had no contract of employment, alongside significant problems with overtime and holiday pay (MRCI, 2012). Migrant workers may also struggle to access social security and other social protection benefits, healthcare and health insurance, reducing their ability to be able to cope with poor wages and working conditions (WHO, 2017).

The specific nature of working conditions differs between work settings. Many countries operate a large informal or ‘grey’ market for older persons’ care, where consumers hire and pay care workers using undeclared methods, such as cash. In this market, migrants are more likely to face lower

salaries and benefits, lower job stability and longer hours (OECD, 2020). It is within in-home care provision that mistreatment and abuse particularly arise. In many countries, a disproportionate share of migrant workers operates within the live-in and home-based care sector. This type of work is most prevalent within the Gulf Cooperation Council (GCC) countries (see Box 6) but occurs in other high-income countries as well. For example, in 2003, a study found that 43% of foreign care assistants lived with their employer, versus 7% of the Italian workforce (Van Hooren, 2014).

Significant cross-country evidence points to the fact that ‘the invisibility and isolated and confined nature of these jobs makes them highly susceptible to employer abuses on the one hand and difficult for the authorities to regulate, inspect and intervene to prevent such abuses on the other’ (Peng and Yeandle, 2017: 52). In-home older persons’ care workers may be unable to leave their employment, and their isolation makes it difficult for them to join unions or otherwise collectively organise (ILO, 2018). Visa conditions, particularly those that are employer-tied, can also increase the potential for both abuse and exploitation, as seen in Box 6 (Smith and Vukovic, 2019).

Box 6 Care for older people in the Gulf Cooperation Council (GCC) countries

Across Arab States, the proportion of individuals aged 60 and above is predicted to rise from 22 million in 2010 to 103 million by 2050 (Hussein and Ismael, 2017). Historically, in GCC countries, care work to support older people has been concentrated among family members, due to both cultural norms and the weakness of institutionalised care services (Sibai and Yamout, 2012; Moghadam, 2021). However, as women's paid work – and the broader affluence of citizens of GCC countries – have increased, wealthier households have begun to rely heavily on domestic workers, many of whom have migrated from South and Southeast Asia, and increasingly East Africa, to take on care work responsibilities (ILO, 2017). Domestic work is the most prevalent occupation among migrant women arriving in the GCC, and across all Arab States, 21.2% of women employed are domestic workers (ILO, 2018). Care facilities outside the home are considered a last resort for lower-income families that cannot afford to hire domestic workers (Sibai and Yamout, 2012).

Under the kafala system, which has defined migration systems in GCC countries, migrant workers are bound to one employer and cannot unilaterally exit the relationship. The system severely limits migrant workers' rights, labour protections and channels to report mistreatment. The reports of abuse have resulted in some governments, including Ghana, Nepal, Sri Lanka and the Philippines, pausing or banning the issuance of visas to domestic workers seeking to migrate to Gulf countries (Kandilige et al., 2019).

Fortunately, some governments have begun to address this problem. In 2015, Kuwait banned employers from confiscating employees' passports, made the opportunity for contract renewal optional and consensual, and created a pathway for domestic workers to file grievances to the Department of Domestic Labour (Human Rights Watch, 2015). In September 2020, Qatar effectively dismantled its kafala system by allowing migrant workers to change jobs without employers' permission (Smith and Zimmer, 2020). Saudi Arabia has also instituted reforms allowing migrant workers to transfer employers once their original work contracts have expired, as well as travel outside the country without employers' permission (Al Arabiya, 2021). That being said, the implementation of these reforms remains limited and many older persons' care workers in the region still struggle to exercise these new rights (Talosig-Bartolome, 2021).

Few countries actively monitor workforce conditions within the home-care industry. While often home-care providers have to register with independent regulators or must become accredited by public agencies, inspections mainly focus on care quality standards (HIQA, 2021). Some exceptions such as Wales, Northern Ireland

and New Zealand have included an emphasis on working conditions, wages and professional development; however, generally the home-care workforce does not often fall under regulatory frameworks (ibid.). Fortunately, there have long been coalitions of both migrant and non-migrant workers advocating for improvements in their

rights. For example, such collaborations led to the creation of the International Domestic Workers Federation (IDWF) and the adoption of the ILO's Domestic Workers Convention (no. 189) (IDWFED, 2014).

Migrants may be drawn to in-home or informal employment if they are undocumented or otherwise operating with an irregular immigration status. In fact, it has been reported that the care sector is unique in employing undocumented migrant workers in countries with otherwise limited undocumented work (Van Hooren et al., 2018). An International Organization for Migration (IOM) study of the older persons' care market in the UK, the US, Ireland and Canada found that experiences of poor terms and conditions were more likely to be reported by people who had an irregular immigration status (Spencer et al., 2010).

Here, Ireland provides a good example. Research has found a high share of undocumented workers employed in domestic work, particularly as older persons' caregivers, with many employed under 'live-in' arrangements (MRCI, 2015). Workers are often expected to be on call at nights and weekends, without alternative cover provision to allow time off, without overtime pay and with minimum wage abuses also observed. The lack of standards and regulation of the home-care industry in Ireland has been linked to these challenges (ibid.) and the subject of debate for some time. The Irish government is actively exploring regulation options for the industry (HIQA, 2021). However, its scoping so far appears to have focused mainly on how to ensure the quality of home-based care, that minimum standards are met, and promoting accountability and value for money, with worker rights and the inspections of workforce conditions receiving less attention (ibid.).

The prevalence of such a large undocumented migrant workforce has led some countries such as Austria, Germany, Greece, Italy, Portugal and Spain to conduct regularisation processes, targeting people who provide care in private households (Van Hooren, 2020; Cangiano, 2014).

These patterns serve to illustrate a broader point: that there is a sharp disconnect between migration policy in many high-income countries and the demands of the older persons' care sector. It is clear from the dynamics described that there is a strong and growing need for a large number of people to work within the older persons' care sector. Yet the large proliferation of migrant workers who are undocumented or otherwise operating with an irregular immigration status, coupled with the large informal or 'grey' market for care, shows that migration policy is poorly serving the needs of the sector at present.

3.3 Impacts of migration for older persons' care

3.3.1 Benefits

Many high-income countries are struggling with large workforce shortages within their older persons' care sector. These shortages compromise patient care and outcomes, reduce the number of care workers available to look after older people and put pressure on those workers who are staffing the sector (Van Hooren, 2020). Migrant workers, by meeting these needs, therefore significantly contribute to the well-being of both patients and other care workers. There is also interesting evidence emerging from the US that migrant labour is associated with improved quality of care in nursing homes and with lower rates of use of institutional care – both significant findings given the challenges facing the US older persons' care system (see the US case study).

Migration also leads to a vast array of benefits for those who move. A large amount of evidence shows that migrants can earn substantially more within countries of destination, while also increasing the wages of future generations (McKenzie et al., 2010; Clemens, 2011; Khanna et al., 2020; Mobarak et al., 2020). Despite the low wages paid to migrant older persons' care workers in high-income countries, it is likely that these wages are still higher than they would be able to access at home. Evidence suggests that many of these migrant workers send back some of their earnings in the form of remittances. For example, the ILO (2020) finds that, in 2018, Filipino migrant domestic workers in Hong Kong SAR, China, Singapore and Malaysia sent back \$1.1 billion in remittances. These remittances are often used for both consumption and investment, reducing poverty and inequality, increasing trade and foreign direct investment, and lowering information barriers (Acosta et al., 2007; Gupta et al., 2009; Javorcik et al., 2011; Kóczán and Loyola, 2018).

Beyond these economic benefits, accessing migration for older persons' care can also lead to a vast array of social and cultural benefits. Women, who dominate the older persons' care workforce, can increase their agency, autonomy and resilience through migration (WHO, 2017). In general, the older persons' care sector provides limited options for up-skilling and skills development, but some workers do report a sense of empowerment. For example, older persons' care workers from the Czech Republic who work in Austria reported that, 'in spite of the precarious work, both the commuting and the earnings led to the migrants' emancipation and re-forming of gender roles' (Sekulová and Rogoz, 2017: 10).

3.3.2 Drawbacks

It is unclear how far the reliance on migrant workers depresses the wages and working conditions of others operating within the older persons' care sector, by allowing employers to plug skills gaps without improving the ethical nature and sustainability of their operations. Decades of research have shown that, on average, the short-term wage effects of migrants are close to zero and that, in the long-term, migrants can actually boost productivity and wages (Peri, 2014). One reason for this is that migrants are often 'complements' to the local labour force, thereby supporting the work of others. For example, older persons' care workers enable women to enter or re-enter the labour force, increasing overall productivity. Yet, this research has also shown that locals operating within low-wage roles are most likely to miss out. For example, research in the UK by Dustmann et al. (2013) finds that while the average effects of immigration on wages are positive, immigration actually depresses wages for locals who are below the 10th percentile in the wage distribution. The UK's Migration Advisory Committee (2018) notes that these findings, along with those of other academics, are imprecise and subject to uncertainty.

In some cases, the exploitative situations encountered by many migrant care workers stem from their inability to change employers under the conditions of their visa. Additionally, because many are working below their qualification levels, this affects their potential earnings and the amount of tax they could pay to their country of destination (WHO, 2017). The process of migration itself may also envelop some of this gain. Recruitment agencies often charge very high placement fees which are disproportionate to the salaries that migrants will earn, forcing many into debt (ILO, 2016; Parreñas, 2021). These factors

all depress the benefits that older persons' care migration could have for these migrant workers, as well as for the countries where they are working. They also, in some cases, violate national and international law and agreements.

Finally, most of these care workers are not able to bring their families with them when they move. For example, the legal migration pathways currently being developed by Australia would allow migrant care workers from the Pacific to move to Australia for up to three years, but with no family accompaniment allowed. The psychological and emotional toll that this separation can have on the migrant workers themselves (WHO, 2017), and on the families left behind, has been widely explored (see Box 7).

Another prominent drawback to migration for older persons' care is that care systems in countries of destination could become overly reliant on this migrant labour. A major finding of the UK government's independent review looking at immigration routes for social care workers is that this dependence can discourage urgently needed investments in, and structural reform of, the sector (Desiderio, 2021). The UK is a prominent example of a country that could fall into this trap given its long history of chronic underfunding and lack of appropriate reform (see UK case study).

Box 7 How 'global care chains' contribute to a 'care drain' in low- and middle-income countries

In recent decades, more women in high-income countries have entered the paid workforce. As men have been reluctant to take on increased domestic and care duties, and as there is a dearth of publicly provided or subsidised care services, migrants have increasingly filled the gap (Hochschild, 2000; Parreñas, 2001; Ehrenreich and Hochschild, 2002; Razavi, 2007; Huang et al., 2012). Often the migrant workers operating within these 'global care chains' are women.

Their movement has three problematic impacts on the families and communities they leave behind. Together, these impacts are known as a 'care drain'. Firstly, those families and communities often must take on additional care responsibilities, to make up for the absence of the primary caregiver abroad (Parreñas, 2005). Secondly, the separation of migrant women from their families and communities, often for years at a time, can have a profound emotional impact (Yeates, 2012). Thirdly, it can lead to a dearth of workers in the care sector in the country of origin.

Though the concept was originally conceived to refer to migrant workers who provide childcare to families in high-income countries, it has since been broadened to include all forms of care, including older persons' care, as well as care provided in institutional settings (Yeates, 2012). As these migrant workers often take on care work outside the remit of full labour and social protections, 'global care chains' often perpetuate entrenched gender disparities in the world of work (Bastagli and Hunt, 2020).

3.4 How immigration systems have been used to meet labour market demand

The large and persistent labour shortages within older persons' care have led many high-income countries to use immigration as a way of meeting demand, whether passively or actively. Here, we explore four different ways that migrant workers have come to be part of the older persons' care sector in high-income countries: through free movement agreements; family, humanitarian and student migration; targeted labour migration pathways; and generic labour migration schemes.⁹

3.4.1 Free movement agreements

Free movement agreements are usually concluded among neighbouring countries with historic, cultural and/or economic ties. They are geographic areas that provide freedom of movement, in that people from one country can work, study and live in another member country without having to obtain a work permit. With regards to older persons' care work, the free movement area of the EU provides the best example. Analysis of the foreign-born share of the care workforce has also found that the demand for labour in older persons' care has been one of the major determinants of labour migration in Europe (Cangiano, 2014). Care work has been the main sector for migration from eastern to western EU Member States, particularly of Polish and Romanian women (Desiderio, 2021). Such arrangements can make migration easier and less expensive, though these patterns of migration may shift in the future. As described above, many

countries of origin of migrant older persons' care workers in Europe are in turn rapidly ageing, particularly Poland, Estonia, Romania and Bulgaria. High-income countries in Europe therefore may need to turn to more targeted forms of labour migration to attract the workers they need.

3.4.2 Family, humanitarian and student migration

All high-income countries allow migrants to enter their territory for reasons other than work. The three main categories of non-labour migration are family (e.g. accompanying a visa holder, or joining a visa holder); humanitarian (e.g. refugee resettlement, or succeeding in an asylum claim); and student (e.g. obtaining a visa for the purposes of study or training). Migrant workers could enter under these categories and then seek to find work in their country of destination, provided that visa rules authorise taking up employment or changing status to employment. Indeed, Spencer et al. (2010) argues that most migrant older persons' care workers are already resident within a country of destination and are recruited locally, having entered through these other routes. For example, in France and the Netherlands, family migration accounts for the largest number of migrant older persons' care workers (Desiderio, 2021). In European Nordic countries, family and humanitarian migration dominate (respectively) the overall migration flows to these countries, so humanitarian migrants play a larger role in the older persons' care sector. Low entry barriers also facilitate employment of these migrant categories. In Ireland, student migration has been noted as particularly important for private home-care

⁹ This section largely draws from two sources. The first is Desiderio (2021), an excellent and detailed review of immigration routes for social care workers, commissioned by the UK's Migration Advisory Committee. The second is the Center for Global Development's (CGD) Legal Pathways Database, which contains information on 60 legal migration pathways (see CGD, n.d.).

agencies (MRCI, 2015). Australia has extensively used its various student and working holiday visas to fill labour shortages at lower skill levels than those allowed through labour migration routes. To meet shortages during Covid-19, it recently announced a temporary relaxation of working limits on international student visas for people working in the care sector (HelloCare, 2021).

3.4.3 Targeted labour migration pathways

Several countries including Canada, Israel and Japan have created targeted migration pathways and new visa schemes, specifically to attract older persons' care workers.

Canada

In 1992, Canada created the 'Live-in Caregiver Program' (LCP), which allowed a Canadian citizen to employ a foreign national as a caregiver if no Canadian citizen or permanent resident was available for the job (CGD, 2021b). Applicants needed to provide at least 30 hours of full-time care to children under 18, people aged 65 or older, or people with disabilities. Between 1992 and 2014, at least 25,000 people accessed the visa. Yet many elements of the programme left caregivers vulnerable to forced labour and personal abuse, including the requirement to live with the family, the conditions for transitioning to permanent residency, and the lack of family reunification. As a result, the scheme was abandoned in 2014.

Five years later, the 'Home Support Worker Pilot' (HSWP) was created, attempting to address the flaws of the LCP (CGD, 2021c). Improvements were made to working conditions that specifically address the potential exploitation of migrant workers. For example, applicants are no longer required to 'live in', nor are they tied to one employer. Additionally, they can bring their

family members with them from the outset and benefit from a secure pathway to residency (Desiderio, 2021). Applicants are required to meet the language proficiency threshold set for the occupation in English and French (CLB 5), a minimum education requirement (Canadian one-year post-secondary or higher), and have a full-time job offer from a Canadian employer in an eligible caregiver occupation. This pilot was launched together with a parallel programme to attract childcare workers. Just 2,750 people per year are eligible to access these pilots, along with their families, with a pathway to permanent residency available. As of late November 2021, the cap had not yet been reached (Government of Canada, 2021a).

Canada also operates region-specific programmes that allow more rural and remote areas to bring in the labour they need, generally on more favourable conditions than federal programmes. For example, the 'Nova Scotia Occupations in Demand' stream (part of the 'Provincial Nominee Program' (PNP)); the 'Rural and Northern Immigration Pilot'; and the 'Atlantic Immigration Pilot' all allow specific geographic areas to bring in older persons' care workers on the basis of lower qualifications and language requirements than the HSWP (Desiderio, 2021). An evaluation of the 'Atlantic Immigration Pilot', analysing the period between March 2017 (the pathway's inception) and the end of FY2019/20 (Government of Canada, 2020), found that it is helping employers to fill labour market needs, particularly in technical occupations and trades at the medium-pay level. Yet the evaluation's negative findings echo informal reviews of Canada's other regional programmes: the migrants themselves face issues with integration, and the communities engaged in the programmes face issues with capacity, overlapping roles and a lack of knowledge of the immigration system (Yantha, 2020; Hagar, 2021).

During the Covid-19 pandemic, Canada launched a number of pathways enabling health and care workers on temporary contracts in the country to transition to permanent status. One of these, the ‘Guardian Angels Program’, aimed to support the transition of asylum claimants who were working as nurses, orderlies and home support workers (Government of Canada, 2021b). Yet in practice the programme was difficult to access, and many of the spots have remained unfilled (Osman, 2021).

Israel

In an attempt to reduce profiteering by private intermediation agencies and secure a pipeline of older persons’ care workers, Israel has signed BLAs with Nepal, Sri Lanka and the Philippines (Raijman, 2020). Migrants from these countries are intended to be the only people who can access Israel’s ‘Foreign Care Worker’ visa (Nefesh B’Nefesh, 2021). This route has been operational since 1991, with 55,000 people accessing the scheme in 2020. Most are women coming from the named three countries, though some also come from the former Soviet Union and India, showing that other countries are still able to access the visa. The scheme does not have a cap in place and has grown tremendously as a result: in 2019, 60% of labour migrants in Israel were caregivers and the sector is now almost entirely populated by migrant workers (Raijman, 2020). Many live in south Tel Aviv, an area populated by refugees and other marginalised populations.

Yet there are large issues with the way the scheme is structured. It is incredibly difficult for caregivers to physically move or change employers, leading to widespread exploitation and abuse (Fox, 2017; Ida et al., 2020). Illegal recruitment fees are common, with many caregivers going into debt to access the migration pathway (Ida et al., 2020). Despite one-third of care workers residing in Israel for more than five years, the route offers no

pathway to residency or citizenship (Niezna et al., 2021). The over-reliance of the sector on migrant workers has been repeatedly questioned. Despite this, Israel has made recent moves to increase the number of migrant care workers in the country, especially to work within institutional settings. For example, 2,000 recruits will soon arrive from Nepal and there are ongoing discussions with Morocco (Middle East Monitor, 2021). In the meantime, the Israeli government is working to improve wages and working conditions, and to ‘professionalise’ the sector to make it more attractive to locals.

Japan

Japan has recently enacted a series of reforms to admit more foreign workers to meet large and persistent skill shortages within a wide variety of professions (Smith and Vukovic, 2019). Prior to 2016, care workers could gain access to Japan as trainees if they were from a country with which Japan had an existing Economic Partnership Agreement (EPA). The establishment of a ‘Nursing Care’ visa route in 2016 liberalised this requirement, seeking to bring in 60,000 new workers in the first five years (Shiraiwa, 2018; TN-Office, 2021).

Potential migrant workers need to obtain a job offer for full-time employment from a care institution, prove a high level of Japanese language proficiency, and obtain a National Care Worker Certification. The pathway provides a route to permanent residency and family accompaniment. Just 257 people arrived for care work under this scheme in its inaugural year (Niki, 2020), a sluggish start partly ascribed to the onerous language requirements that have since been relaxed (Japan Times, 2019).

Due to the scheme’s demanding language and certification requirements, Desiderio (2021)

argues that it is probably more targeted towards foreigners already in Japan, including those who have arrived for study (whether in a training facility for care workers or elsewhere), and those who have entered through the ‘Technical Intern Training Program’ (TITP) (CGD, 2021d). The TITP has, since 2016, allowed admission of trainees with extensive working rights from nine Asian countries to enter the Japanese older persons’ care sector (among others). It is controversial for having facilitated large-scale human rights violations including forced labour and human trafficking, and the fact that it allows Japanese employers to hire migrant workers for temporary, low-paid work (IHRB, 2017; Sugi, 2018; Toshihiro, 2019). This could be slowly changing, however; recent indications suggest that Japan may be considering allowing foreign nationals who are working in a range of services (including care) to stay indefinitely (Lang, 2021).

3.4.4 Generic labour migration pathways

Other high-income countries have allowed for the admission of migrant older persons’ care workers through their generic labour migration pathways. In a few instances, older persons’ care work has been added to shortage occupation lists which are used by many countries to grant preferential access to, or terms for, a visa for migrants in sectors that are experiencing shortages. Here, the examples of Australia and New Zealand are worth highlighting. The Republic of Korea provides an interesting example of a mixed migration route that has been used to cater for their older persons’ and childcare needs. The examples of China, the UK and the US are further discussed in their own sections below.

Australia

Since 2008, the ‘Temporary Skilled Shortage’ (TSS) category of Australia’s labour migration

programme has allowed migrant workers to enter Australia within certain shortage occupations, with some of them then pursuing work within the older persons’ care sector (Government of Australia, 2021). Practically, however, the only federal labour migration route into ‘low-skilled’ older persons’ care work consists of the labour agreement streams of the TSS visa such as the ‘Designated Area Migration Management Agreements’ (DAMA). These allow specific regions and employers that are facing acute worker shortages to pursue specific agreements to bring in targeted numbers of workers whose skills are ‘lower’ than those normally required for admission under the TSS.

To meet persistent skill shortages within the older persons’ care sector, Australia plans to go further still. The Department for Foreign Affairs and Trade (DFAT) has been exploring ways to use the Pacific Labour Facility (PLF) to facilitate the migration of care workers trained by their ‘Australia Pacific Training Coalition’ (APTC) (CGD, 2021e). Graduates from the APTC receive a qualification equivalent to that called for by a recent Australian government royal commission, meaning that this pathway could facilitate large-scale mobility (Commonwealth of Australia, 2020). Migrants will receive two- or three-year visas, without family accompaniment, and will largely be working within rural and remote areas of Australia. Discussions are ongoing, and it remains to be seen whether the benefits of this approach outweigh the substantial financial outlay required to train older persons’ care workers and the detrimental emotional impact of the lack of family accompaniment.

New Zealand

In the past, New Zealand included a few older persons’ care occupations within its shortage occupation lists, enabling people with few formal qualifications to qualify as ‘skilled migrants’.

However, in practice, the relatively high salary threshold and other requirements made it difficult for older persons' care workers to qualify for these visas.

As a result, in 2008, the New Zealand government created an 'Essential Skills Work' visa which allowed accredited employers who had passed a labour market test to offer full-time roles to migrants entering the older persons' care sector (New Zealand Immigration, 2021b). The visa was for an initial period of 12 months and could be renewed an indefinite number of times, yet there was no straightforward path to residency due to the skill level of the roles included. As a result, almost one-third of those people who obtained this visa for care work in 2008 were still on the visa in mid-2012. Despite this difficulty, 37% had secured residency within three years, with most transitioning to a 'higher skill' code such as a registered nurse (Howe et al., 2019).

In early 2021, the New Zealand government announced a 'reset' of the country's immigration system, arguing that the country's reliance on 'low-skilled' migrant labour had allowed businesses to suppress wages and avoid investing capital in equipment and in up-skilling locals (Radio New Zealand, 2021). Six different work visas, including the Essential Skills Work visa, were phased out in November 2021, with a new 'Accredited Employer Work Visa' opening in mid-2022 (New Zealand Immigration, 2021a). Employers will need to be accredited before they are able to hire foreigners, and any positions must go through a labour market test and offer a minimum salary of NZ\$79,560. Given the average base salary for a caregiver in New Zealand is NZ\$41,952, it is unlikely that these positions will qualify under the new visa (Indeed, 2021).

Republic of Korea

Since 2007, the Republic of Korea has used the 'H-2 (Working Visit)' permit to admit ethnic Koreans who currently live in other countries to migrate to and work in the Republic of Korea, including within low-qualified professions (Korea Visa Portal, 2021). H-2 visa applicants must undergo a three-day training course in the Korean language, culture and law, and can then receive a temporary permit that can be renewed every three years (Desiderio, 2021). The visa also provides a pathway to permanent residency. This has allowed Korean households and employers to hire older persons' care workers, mostly from China. While there is a cap on admissions in place, this has not yet been met. This migration of Korean-Chinese (co-ethnic) migrants has become the most important migration path to the Republic of Korea, with 234,666 'unskilled' people moving in 2014 (Kim, 2016).

The H-2 visa was introduced alongside the establishment of the Republic of Korea's Long-Term-Care Insurance (LTCI) system. The vast majority of older people employ migrant workers either through this public LTCI system, or through recruiting in-home support (Peng, 2017). Evidence suggests that 97% of migrant care workers choose to operate within the informal, home-based care market, rather than the public LTCI system (Desiderio, 2021). This appears to be because wages are higher in the informal care market as workers can work longer hours and are provided with free accommodation. Yet this system is still not keeping pace with demand: in March 2021, the Korea Employment Welfare Pension Institute began exploring whether to legalise the hiring of foreign nationals as domestic workers (Ji-hye, 2021).

Despite the efforts of the countries described, many external experts have cautioned against migration being seen as the solution to the deficiencies of the care sector and highlight the urgent need to reform older persons' care delivery, including increasing funding, improving wages and working conditions, and improving the quality of care (Spencer et al., 2010; ILO, 2018). However, it is likely that at least some well-managed migration will be required to meet the scale of immediate demand, with the significant added benefit of potentially improving outcomes for those who move and for their home communities. How to do this in an ethical and sustainable way is the focus of the remainder of this section.

3.5 How to promote ethical and sustainable migration for older persons' care

Little attention has been paid to the impacts of care work migration on countries of origin, and to ways in which these impacts could be mitigated by countries of destination. The appropriate framework for such a discussion is the World Health Organization's (WHO) 2010 *Global Code of Practice on the International Recruitment of Health Personnel* (WHO, 2010). WHO sees healthcare on a continuum, with the older persons' care workforce specifically included in their definition of 'health worker' (WHO, 2006).

The WHO Code was developed to respond to concerns of a 'brain drain' among countries of origin – whereby their most qualified health professionals were leaving for better opportunities abroad. It outlines a number of principles that should be followed to ensure ethical and sustainable health worker recruitment, following similar principles outlined by the ILO in its numerous fair recruitment and labour

migration initiatives (ILO, 2006; 2021c). Crucially, any recruitment from countries that have a 'critical shortage' of health workers must be done through a bilateral government-to-government agreement that includes a tangible benefit for the country of origin, such as technical or financial assistance (Clemens and Dempster, 2021).

Since the WHO Code was signed, there has been a concerted effort by international and national bodies to promote its use. In 2021, for example, WHO formed a Technical Expert Group to design a new set of bilateral recruitment guidelines, based on the WHO Code, which could be used by countries of origin and destination in designing new migration agreements. Yet, the WHO Code is not yet widely used by countries implementing healthcare migration pathways. Concern about 'brain drain' leads many countries to shy away from exploring healthcare recruitment. For those countries that are developing migration agreements, greater concerns predominate. Countries of destination are focused on meeting their worker shortages and are largely unconcerned with the impact on countries of origin. Countries of origin are focused on exporting 'surplus' health workers and receiving remittances, rather than arguing for a greater development benefit (Clemens and Dempster, 2021).

Some countries have seen disappointing results, despite their intention to live by the WHO Code principles (Tankwanchi et al., 2015; Abuagla and Badr, 2016; Van de Pas et al., 2016). A review of practices in Sudan, for example, concluded that although the WHO Code had led to the creation of bilateral agreements and had stimulated some health workforce development efforts, its aims have not been fully implemented (Abuagla and Badr, 2016). High levels of emigration of Sudanese health workers had continued, with

few parallel investments in Sudan, due to the Sudanese government's weak negotiating power (ibid.). Wider sub-regional reviews in Africa find similar results in terms of a lack of health system strengthening and failure to address local workforce challenges (Van de Pas et al., 2016). A global review also identified constraints in relation to comprehensive data on health workforce migration, the lack of short- and long-term workforce planning, and poor coordination between stakeholders (Siyam and Dal Poz, 2014).

Other major issues include the voluntary nature of the WHO Code and – particularly relevant to older persons' care – its effectiveness in the context of privatised service provision. This aspect has been specifically raised as a challenge in the context of health worker migration to the US (Tankwanchi et al., 2015). Where the WHO Code appears more effective is in ensuring that migrant health workers enjoy the same rights and opportunities as local health workers. A WHO review found 'clear evidence of equity and fair treatment by receiving countries' (Siyam and Dal Poz, 2014: 12) and case studies have shown how the WHO Code has been successfully leveraged by local civil society actors to influence working conditions in Germany and Italy (Van de Pas et al., 2016).

Despite older persons' care workers falling within the definition of 'health worker', to date, no countries have used the WHO Code to negotiate new bilateral migration agreements to facilitate the movement of such migrants. There are, perhaps, good reasons for this. The signing of the WHO Code was motivated by concerns around the migration of doctors and nurses: people whom the country of origin had paid to train. There may be less concern about 'lower-skilled' workers leaving countries of origin, and less concern about receiving compensation for their movement. In addition, there is largely (as yet) no older persons'

care workforce in countries of origin that the movement of these people would be undermining. However, as discussed earlier, the recruitment of senior care workers may lead to the migration of qualified nurses from a country of origin. As such, expanding international recruitment for the long-term care sector could directly undermine nursing workforces, hence application of the WHO Code remains essential. In addition, with the expected demographic changes in these countries of origin, this point will become more pressing in the years to come.

Fortunately, use of the WHO Code may be increasing. For example, in 2021, the UK became the first country to implement its own domestic form of the Code. Using their Code as a framework, the National Health Service (NHS) is negotiating several agreements with potential countries of origin with a view to providing technical and financial assistance to improve their health systems and training regimes (Adhikari et al., 2021). In late 2021, the scope of the UK Code was broadened to include the long-term care sector, likely to coincide with the changes to the shortage occupation list and the Health and Care Worker Visa (see UK case study) (NHS Employers, 2021). The extent to which the UK can successfully apply the UK Code principles to its adult social care system remains to be seen. Critical barriers in England include the lack of a regulator concerned with the social care workforce and the lack of professional accreditation standards and processes for care worker roles. Essentially the sector is lacking the underlying framework to support the Department of Health and Social Care (DHSC) in its application of the UK Code. In addition, the fragmented nature of older persons' care provision, with multiple private providers, implies significant challenges, given that a regulator or national agency would be required to monitor all recruitment activity, including that

of private recruitment agencies. This is already a difficult area, with reports of active recruitment from countries with critical shortages into private nursing homes in the UK, with workers later moving into the NHS workforce once settled in the country (Nolen, 2022).

It is imperative that any country seeking to increase health worker migration, including older persons' care workers, abide by the principles in the WHO Code. This is particularly relevant because the sustainability of both health and long-term care systems are integrally linked (OECD, 2020) and a coordinated approach to meeting needs across both is required. Countries' adherence to the WHO Code would also help to ensure that migrant workers are afforded the same rights and protections as local workers, and that there is some form of 'mutual benefit' to countries of both origin and destination.

In their efforts to attract much-needed workers, high-income countries will need to reconfigure their development cooperation with countries of origin to ensure the 'mutual benefit' included in the WHO Code. One move that has been seen within the broader health worker space has been the promotion of Global Skill Partnerships, whereby the country of destination invests in training additional workers within a sector who remain in the country of origin (Adhikari et al., 2021). Such an approach would be particularly pertinent for countries of origin in Asia, which are in need of their own older persons' care workforce. For countries of origin in Africa, 'mutual benefit' could take the form of investments in training and skill upgrading that can serve the immediate needs of their underdeveloped health systems and workforce, while looking to strengthen the older persons' care sector in the longer term. In both cases, investments could be used to enhance mutual

skills and qualification recognition, to make it easier for people who are qualified in older persons' care skills to access roles across the globe.

While permanent, or at least long-term, migration may be in the best interests of the country of destination, it may not be in the best interests of the country of origin. Experimenting with circular migration schemes could help to mitigate the 'care drain' in countries of origin by ensuring that workers return home to contribute their skills. Of course, the structure of the pathway would need to be such that those returning workers could quickly plug back into the local labour market (say, as a community health worker or nursing assistant) and that their newly gained skills were not wasted. Designing schemes to enable this are quite feasible given the skills similarities between, for example, long-term care workers and nursing assistants.

The ageing demographics and migration flow dynamics outlined above make two points clear. Firstly, the scale of demand in countries of destination will be substantial, likely far beyond what migrant workers will be able to meet, at least by current immigration systems. Secondly, primary countries of origin are themselves ageing and will be unlikely to supply migrant labour at the same rate in the decades to come.

Both of these points serve to reinforce the fact that countries of destination need to explore broader structural reforms to their older persons' care sector. Part of these reforms must include improving wages, working conditions, advancement opportunities and labour protections to make the sector more attractive to the domestic workforce. This will require serious commitment, financing and policy reforms – reforms that are unlikely to be easy or achievable

in the short term. Further, given the scale of workforce challenges, employing both local and migrant workers appears to be the only way currently to provide safe and high-quality care for older people. As such, countries of destination will need to pursue ethical and sustainable health worker migration in line with the WHO Code, as well as broader improvements to the older persons' care sector.

4 Country case study: China

4.1 Overview of the older persons' care sector in China

In China, older people have traditionally looked to their families for care and financial support.¹⁰ The Confucian norm of 'filial piety' (an attitude of respect for parents and ancestors) has engendered a practice in which family members, primarily women and girls, engage in unpaid care labour in a household setting; and a culture in which external care is viewed as a normative anomaly, associated with an underlying failure of care (Strauss and Xu, 2018). Until recently, this tradition has largely persisted. The nationally representative China Health and Retirement Longitudinal Study (CHARLS) 2011–2012 baseline survey reported that approximately 41% of Chinese citizens aged 60 and older lived in intergenerational households. Another 34% lived near their adult children, an arrangement intended to guarantee they could provide care when needed. Where China's pattern of rural to urban migration made traditional intergenerational care no longer feasible, it is the family that is looked upon to shoulder the cost of external care (Lei et al., 2015).

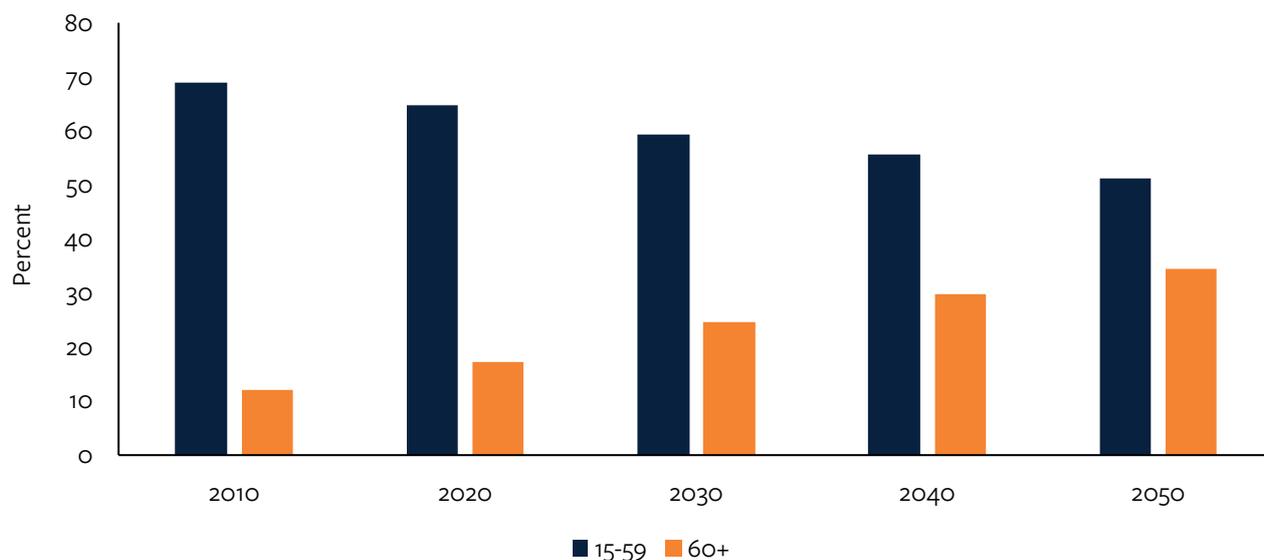
The One-Child Policy¹¹ has put a strain on this tradition. It has created the '4:2:1' problem: each child of the one-child generation will now have to care for two parents and four grandparents. According to a census conducted by the National Bureau of Statistics of China in May 2021, the share

of people aged 60 and older has grown to 18.7% (from 13.3% in 2010) while the country's working-age population (defined as individuals between the age of 15 and 59) has dropped from 70.3% of the total population to 63.4% within the same timeframe (National Bureau of Statistics of China, 2011, 2021). The UN Department of Economic and Social Affairs shows the percentage of the population aged 60 and older as growing from 12.2% in 2010 to 34.6% in 2050 (Figure 13). This will leave over 110.5 million people dependent on assistance to carry out basic activities (WHO, 2015; Xinhua, 2018). As Figure 13 shows, this rapid ageing will take place alongside commensurate shrinking of the working-age population, with the make-up of the population in 2050 looking dramatically different from that of today. Feng et al. (2012) call this China's 'demographic tsunami', referring to the rapidly shifting age structure in the country.

The demographic pressure caused by the One-Child Policy – combined with the effects of accelerated modernisation, continued rural-to-urban migration, the changing role of women in Chinese society and growing morbidity among older people – has eroded the system of family care, and has led to rising demand for formal older persons' care in China (Habib, 2019; Wang et al., 2020). In response, the government has launched various policy initiatives to increase older persons' care services, beginning with the 2011 *Twelfth Five-Year Plan for the Development of Aged Care*

10 In this paper, we use the term 'China' to refer to the People's Republic of China. Largely, the data presented here for 'China' *excludes* both the government of Hong Kong and the Republic of China (Taiwan).

11 The One-Child Policy was a programme implemented in 1979 to control population growth by limiting most families to one child each. It was lifted in 2015, and in May 2021 the three-child policy allowing all couples to have up to three children was introduced.

Figure 13 Demographic shifts in China, 2010–2050

Note: This figure uses UN DESA estimates for data up to 2020 and UN DESA ‘medium variant’ projections for population ageing by age group after 2020.

Source: UN DESA Population Division, 2019

Services in China. The Plan sets forth concrete numerical targets, along with softer policy goals, to create a social care service system with three levels, based around a 90-7-3 framework (Alpermann and Zhan, 2018): 90% of Chinese older people will be provided with home-based care, 7% with community-based care, and 3% with institutional care (Maags, 2020).

While home-based care includes familial care, it is increasingly reliant on professional institutions and caregivers. Community-based care is intended for healthy older people with reasonable mobility or with relatively limited means. It enables older people living at home to access care at community centres, which receive economic subsidies either via direct allowances (to both providers and users of the system) or indirectly through government purchases of community care services. These centres can take multiple forms, including day care centres, community care management centres, and integrated community care centres. They provide services encompassing meals, personal

care, healthcare, household care, emergency assistance, information services, spiritual care and legal assistance (Du Peng, 2015). Different local governments are also experimenting with a variety of models. For example, some local governments are trialling voucher systems, providing targeted groups of older people, such as those with high needs or those without children, with personal allowances in the form of cash or vouchers to arrange and fund their own long-term care (Glinskaya and Feng, 2018). Community-based care models also vary across provinces, with the province of Qingdao following a mutual-aid model in which older people band into teams that provide voluntary and reciprocal support, and all volunteers are given monthly subsidies (Zhang and Yang, 2019). Finally, institutional care is intended primarily for older people with disabilities and more complex conditions and refers to the provision of 24-hour professional care in institutions such as nursing homes (in urban areas), homes for older people (in rural areas), hospices and nursing stations (Du Peng, 2015).

In addition to cultural traditions like ‘filial piety’, the system’s emphasis on home-based care reflects the still severe shortage of outside care providers and facilities, and the substandard quality of many of those available. The Chinese government has introduced a number of policies focusing on increasing the supply of older persons’ care services to meet escalating needs. A trend towards private sector involvement and the commercialisation of care has become evident (Maags, 2020). For example, the 2016 *Thirteenth Five-Year National Plan of Undertakings on Ageing and Development of an Aged Care System* includes granting private and not-for-profit institutions greater access to the older persons’ care market. Regulations have been released exhorting local governments to assist older persons’ care institutions established by such actors through taxation, subsidies, access to construction land, exemptions from permit requirements, and other incentives (Alpermann and Zhan, 2018; Habib, 2019).

The older persons’ care market thus has a mixture of private and public providers, with services often subcontracted out to private companies. In some locations, however, the role of the public sector is more prominent. For example, in Shanghai, the city administration is funding home-based care services for older people on low incomes in response to rising demand (Peng and Yeandle, 2017). Generally, the Chinese government aims to reduce its role in providing older persons’ care beds to no more than a 50% share; a senior official with China’s Ministry of Civil Affairs announced in 2019 that this goal had been met, even as the number of facilities has rapidly increased, reaching 220,000 from only 173,300 in 2019 (English.gov.cn, 2017; Xinhua, 2019a; Maags, 2020; Zhang, 2021).

Certainly, the public funding channelled into partnerships with the private sector to build and operate older persons’ care services has resulted in a rapid expansion of private care facilities and a reduced role for the public sector. It has led to increasing investor interest from both foreign and domestic investors – including private equity funds – that are seeking to invest in older persons’ care facilities in China (Feng et al., 2012). However, it has also made institutional care for older people ‘more difficult and expensive for low and middle-income elderly households to access’ and has ‘resulted in more unequal access’ (Peng and Yeandle, 2017: 28). This highlights the need for stronger regulatory oversight of private care provision (Feng et al., 2012).

There appear to be no clear estimates of China’s public expenditure on older persons’ care (Glinskaya and Feng, 2018). Much of the spending allocated comes from the Public Welfare Lottery Fund, a fund that collects money from different types of lottery sales and is distributed between central and local governments to support social security and public welfare projects. In the field of older persons’ care, it supports expenditures in areas such as infrastructure, subsidies to privately run nursing homes (usually per bed) and training of workers (ibid.). China is also exploring a variety of options for financing its long-term care sector, particularly because older people are mainly expected to pay out of pocket, with many struggling to do so due to the high costs of institutional care. Over the past decade, public long-term care insurance schemes have been piloted, with initiatives expanding to 15 cities in 2016 (Yang et al., 2021). As the design of the schemes is variable across locations, levels of coverage and eligibility criteria are different, yielding different impacts in terms of access to care, with the schemes likely to change as policies

evolve in this area (*ibid.*). The World Bank, noting the difficult experiences in the UK and the US with means-tested systems, has recommended that China considers developing a universal, public long-term care financing system, similar to the social insurance models in the Netherlands, Germany and Japan (Glinskaya and Feng, 2018).

4.2 The care workforce and employment practices

China suffers from an acute shortage of older persons' care workers; the China National Committee on Ageing reported that about 80% of families seeking assistance have unmet care needs (Glinskaya and Feng, 2018). Official estimates of the size of the care workforce and care shortages do not appear to be available. Xinhua (2019b) notes that, with nearly 41 million people in need of care, the country's older persons' care sector should have at least 13 million workers. But Glinskaya and Feng (2018) state that, in 2015, China reportedly had just 1 million older persons' care workers. In 2017, a study from Beijing Normal University (BNU) found there were fewer than half a million workers (Xinhua, 2019b). Shortages are more acutely felt in rural areas, particularly in those that are remote and less economically developed, where there is a significant lack of home-based, community-based and institutional care services (Feng et al., 2012; Glinskaya and Feng, 2018). Coverage and access in rural areas are major challenges, given that forecasts of the share of the population over the age of 60 are much higher in rural than urban areas (estimated at 60% compared to 30% by 2050) (Habib, 2019). Alongside the sheer scale of the workforce shortage, there are challenges with training of staff. Data from 2015 found that only 20,000 of China's 1 million older persons' care workers were trained (Glinskaya and Feng, 2018), with this

shortcoming once again more pronounced in rural areas.

Most older persons' care workers are older women who either lost their previous jobs during a period of public sector reform and restructuring or are internal migrants; they also have low levels of education and training (Feng et al., 2011; Song et al., 2014). A 2012 survey conducted by the Ministry of Civil Affairs of 2,158 older persons' care workers across 15 provinces found that 83.5% of these workers were women and 79% were older than 40 (28% were aged over 50). About 45.2% listed junior middle school as their highest educational attainment, and 40% had less than two years of experience in the older persons' care sector. Most of these workers were highly mobile and initially from rural areas (Glinskaya and Feng, 2018). More recent studies draw an identical picture of the older persons' care workforce (Feng et al., 2012; Fang, 2013; Song et al., 2014; Meng et al., 2015; Habib, 2019).

As with other countries, workforce shortages are largely driven by wages and working conditions. Older persons' care workers in China receive low pay and few fringe benefits, are accorded low status and have limited career prospects. A study conducted in 2014 found that older persons' care workers in Shanghai earn 28% less than other domestic workers – an already low-paid, low-status group that frequently suffers discrimination. The Ministry of Civil Affairs estimates that only 65% had signed labour contracts, suggesting that older persons' care workers have less stable employment (Hu, 2013; Glinskaya and Feng, 2018). Moreover, home- and community-based older persons' care workers are typically not covered by labour market regulations, and must turn to the China Home Service Association – a not-for-profit closely affiliated with older persons' care service agencies – to air any grievances. Traditional

notions of care work as not being ‘decent’ or respectable also propagate a view of older persons’ care workers as belonging to the lowest strata of society. All this, in combination with the difficult nature of care work, means even the most ‘low-skilled’ workers prefer other forms of low-paid work (Glinskaya and Feng, 2018).

The shortage of older persons’ care workers is compounded by China’s shortage of healthcare professionals overall. In particular, China’s nursing shortage has only grown more severe in recent years; in 2017 China had only 2.73 nurses for every 1,000 people (Zhou et al., 2018).¹² Given the lack of programmes that provide training in geriatric nursing, there is likely an even more severe lack of nurses qualified to provide older persons’ care. A study conducted in 2012 found that only 10% of nurses on average in China had certified geriatric nursing qualifications (Habib, 2019). This deficit has important consequences for older people with disabilities and those who are sick and in need of medical care.

4.3 Policy responses to workforce shortages

China’s response to the older persons’ care worker deficit has focused on three things: developing training opportunities, encouraging ‘smart care services’, and raising the retirement age (an aspect not covered here as it is outside the scope of this report). To address the shortage of qualified workers, the Ministry of Civil Affairs released the 2010–2020 *Medium and Long Term Development Plan for Civil Affairs Personnel*, which aimed to raise the number of nursing caregivers to 6 million by the end of 2020 –

though there were only 30,000 in the industry in 2010 (Han et al., 2020). The State Council released *Accelerating the Development of Services for the Aged*, aiming to engender an improvement in training and employment policies. Policy initiatives to require certification for care workers – like the 2011–2015 *Plan for the Development of Social Service System*, which aimed to have all workers certified by 2015 – have also been introduced (Glinskaya and Feng, 2018). While these initiatives have had limited success, the emphasis on training and recruiting has remained, with the Ministry of Civil Affairs aiming to have 2 million more certified caregivers by 2022 (Reuters, 2019).

Vocational schools continue to be established and training programmes launched, in a bid to increase the number of locally skilled workers for the older persons’ care industry. In 2019, the government announced that the earnings of the older persons’ care, childcare and domestic services industries would be exempt from value added tax (VAT) and will benefit from a 10% deduction in taxable income. The policy, which will run until 2025, was announced alongside a raft of other interventions. These interventions aimed to increase the number of training facilities for older persons’ care, as well as facilities to support older people (Zhang, 2019). Some local governments have now enacted parallel policies (Habib, 2019).

China has introduced numerous plans and policy documents encouraging the private sector to expand into ‘smart ageing’, spurring the development of technologies to respond to the demand for intelligent devices that assist older people. The 2017–2020 *Action Plan for the Development of Smart Elderly Care Industry*

¹² The average among 33 OECD countries is 9.22 nurses per 1,000 people. Norway has the greatest number, at 18.05, while Turkey has the lowest at 2.4. More than 55% of WHO Member States have fewer than four nursing and midwifery personnel per 1,000 people. For more information, see OECD (n.d.) and WHO (n.d.).

encouraged the private sector to invest in smart ageing, identifying services such as telemedicine and products like portable gadgets for health monitoring, self-diagnostic devices, robot butlers and alert systems as focus areas for innovation (WHO, 2021). The *Thirteenth Five-year Plan for the Ageing Development and Elderly Care Services* complemented this, announcing the establishment of a community-based older persons' care service information platform, service order system and emergency rescue mechanism. Finally, the 2016–2020 *Thirteenth Five-year Plan for Healthy Ageing* proposed the use of information technologies to 'explore the new models of care services for the elderly' and to establish smart health pilot projects for home- and community-based care (Zhang et al., 2020). Certain local governments have also included the digitisation of older persons' care in their own Fourteenth Five-year Plans.

The smart ageing sector, valued in 2019 at nearly 3.2 trillion yuan (approximately \$504 billion as of 8 December 2021), has continued to grow rapidly, with the central government and certain local governments providing significant subsidies to those entering the industry (Xinhua, 2020; Shasha and Xiaoyi, 2021; Sito, 2021; Yongling and Yuanyuan, 2021). But while a 2019 study found sufficient evidence that the sector could significantly improve the quality of life of older people while reducing the burden on and need for care workers, the industry is still in its infancy and has only been promoted in select developed cities. The study concluded that the action plans put forth are too general to effectively execute, and that there is a need to develop adequate regulations to enable nationwide promotion (Meng et al., 2019).

China's Fourteenth Five-year Plan also aims to enable more rural-to-urban migrants – many of whom end up working in older persons' care – to fully access public services from which they have traditionally been excluded (Asian Development Bank, 2021). While this has important consequences for the older persons' care workforce, there is no evidence to suggest this was done specifically as a response to older persons' care shortages.

4.4 Immigration policies and the care sector workforce

4.4.1 Internal migration

Most older persons' care workers in Chinese urban areas are rural migrants who move to cities to seek greater economic opportunities. This rural-urban migration peaked during the period from 1990 to 2010; domestic work in particular became an attractive employment option for rural women due to the sheer number of opportunities (Minghui, 2017). For example, in Shanghai, the number of migrant care workers increased from 300,000 in 2009 to 490,000 in 2013.

Many of these rural-to-urban migrants operate as domestic workers, often living in the home of the family whom they are supporting. The Asian region relies more on domestic workers than any other region of the world; of the 75.6 million domestic workers globally, 50% are employed in Asia and the Pacific (ILO, 2021b). In 2016, IOM surveyed 156 Chinese domestic workers from 22 provinces and cities, then working in Beijing, with generally positive findings (Minghui, 2017). On average, the education level was relatively low (the majority had only a junior high school education) and they were older than other migrant workers

(with an average age of 42.2 years). They could command relatively high wages, which offsets the amount they must pay to recruitment agencies.¹³ While only 8% had a labour contract, they largely operate within the boundaries of the law, working between 8 and 12 hours per day and having four rest days per month. Only small numbers (< 5%) had suffered from verbal or physical abuse (Minghui, 2017). Workers operating through a domestic service company have dispute resolution and complaint services available to them, a recourse not available to directly employed domestic workers.

4.4.2 International migration

The rural-to-urban migration trend, Putnam (2021) argues, ensured that China has (to date) avoided the economic growth implications of an ageing population. Yet even prior to the Covid-19 pandemic, this trend was beginning to slow and perhaps even reverse, signalling a potential end to this stream of workers. Given the scale of need outlined above, and the lack of both rural-urban migrants and working-age people overall, it is likely that some international migration will be needed in the coming decades.

Yet policy discussions within China have largely ignored the recruitment of international migrant workers as a potential solution to the older persons' care worker shortage. The current system for admitting immigrants is based on academic qualifications, professional experience and income. In addition, a 1996 regulation limits foreigners to taking up employment that cannot be filled by Chinese nationals (Pieke, 2012; Ding

and Koslowski, 2016; ILO and IOM, 2017). As a result, China's immigration policies largely focus on attracting 'highly skilled' foreign labour, while restricting the entry of 'low-skilled' workers. In particular, there is a focus on securing workers with the ability to promote technology transfer or take the lead on industrial projects (Kim and Allen, 2018). Østbø Haugen and Speelman (2022) argue that political and bureaucratic issues, as well as the domination of security authorities over migration processes, has meant a more comprehensive system has been slow to materialise.

Despite these restrictions, international migrant workers have found ways to enter China in the past, usually through tourist or business visas. Some of these people have ended up working within the older persons' care sector, particularly as domestic workers (Lanlan, 2020). This is largely due to high demand for such workers, and the lack of uniform and appropriate regulation governing the sector (Donglin, 2017). For example, in 2015, the Philippine Overseas Employment Agencies warned job seekers to be cautious of recruiters in China who were offering domestic work, as it is illegal for Filipino workers to operate as domestic workers in China on a tourist or business visa (POEA, 2015). In 2020, Hall et al. (2020: 1) observed that 'most Filipina domestic workers are working illegally due to labour policy restrictions currently in place'. Indeed, Filipino workers comprise the largest group of international migrant domestic workers in China, largely in Macau; as of 2017, 13,535 Filipinos were reportedly employed as domestic workers (Hall et al., 2019). Yet Filipino domestic workers in China appear to encounter a range of obstacles, including poor

13 The average monthly income reported was CNY3,000 (approximately \$472 as at 11 February 2022). They can also access double wages if they choose to work on holidays instead of taking a day off. For-profit intermediary agencies charge about CNY1,500 (approximately \$236 as at 11 February 2022) in training fees. One month's wages are also deducted as a guarantee on their contract (Minghui, 2017).

physical and mental health, poor social integration and discrimination, and a lack of access to health services (Hall et al., 2020).

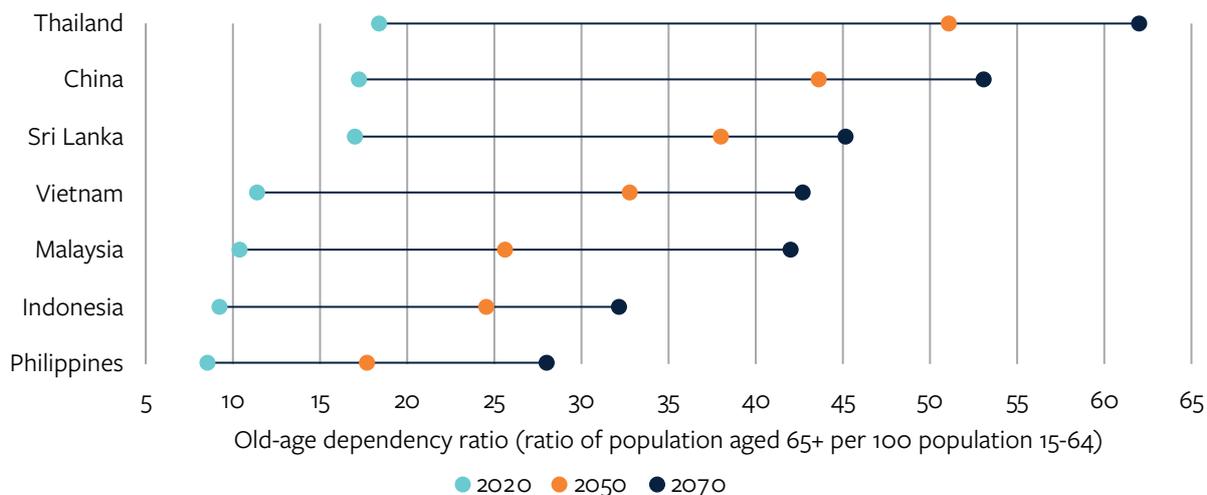
There are some signs that China’s migration regime may be starting to loosen. In 2018, the Chinese government signed a bilateral agreement with the Philippines that conditionally lifted its restriction on foreign workers. It paved the way for the employment of 300,000 Filipino workers – primarily English language teachers, but including cooks, caregivers, household service workers and nurses – and allowed local residents to directly employ some as domestic workers following a trial period in five major cities (Dacanay, 2018; Hall et al., 2020).

Outside this bilateral agreement, there seems to be little sign that the Chinese government is exploring relaxing their immigration regime. While migration management is higher on the policy agenda, there is little policy debate focused on migration for older persons’ care (Østbø Haugen and Speelman, 2022). There is also little sign that

China is seeking to negotiate agreements with new countries of origin. Certainly, other countries in the region, including Indonesia, Malaysia, Sri Lanka, Thailand and Vietnam, are positioning themselves to be ‘the new Philippines’ in the region as well as globally. For example, until the early 2000s, the Philippines was the largest country of origin for older persons’ care workers in Japan, the Republic of Korea, Taiwan, Hong Kong and Singapore. Since that time, Indonesia and Vietnam in particular have increased in importance as countries of origin (Peng, 2017). The majority of these countries are younger than China (see Figure 14) and may be the recipients of new bilateral agreements in future.

It remains to be seen whether its bilateral agreement, and the other reforms outlined above, will be enough to meet the growing demand for older persons’ care workers throughout China. As the ‘demographic tsunami’ comes to pass, and rural-urban migration slows, it will be imperative for China to look elsewhere for older persons’ care workers, while at the same time rapidly modernising their long-term care system.

Figure 14 Ageing trends in China and potential countries of origin



Note: This figure uses UN DESA ‘medium variant’ projections.

Source: UN DESA Population Division, 2019

5 Country case study: United Kingdom (UK)

5.1 Overview of the older persons' care sector in the UK

In the UK, older people are cared for in both residential care settings and in domiciliary or home care, where paid care workers assist those at home with daily living activities (Skills for Care, 2020). Since adult social care (the term used to describe long-term care in the UK) is a devolved competence, variable arrangements in how services are commissioned and accessed have resulted in care systems that are more generous in Scotland, Wales and Northern Ireland than in England (Oung, 2020). In this case study, we will focus on England, drawing on experiences from the other UK nations as relevant.¹⁴

Over the past 20 years, the role of local authorities in providing care has dropped significantly, from 95% to 11%, in relation to the direct provision of home care (Stanley et al., 2021). With regard to residential care, the vast majority (84%) of care home beds in England are now in the for-profit private sector (Campbell, 2019). The current outsourced, market-based model has led to a high level of fragmentation in the provision of care for older people.

An older person can access care by arranging and paying for it privately, turning to unpaid family members or friends for help, or requesting

support from the local authority (which is provided on a means-tested basis). Local authorities provide residential care and home-based care, as well as direct payments to enable families to purchase care services themselves. While fully private arrangements have increased, local authorities still pay for most formal care that is provided (National Audit Office, 2021). Private providers rely substantially on local authority-arranged care for the majority of their income (65%) and public funding remains essential to the sustainability of the sector (National Audit Office, 2018).

The sector has faced an extended period of underfunding, with local authority spending on adult social care in 2019/20 lower in real terms than in 2010/11 (National Audit Office, 2021). This has caused major financial pressures for private providers, many of whom receive less than the full cost of care provided (National Audit Office, 2018). It has also resulted in the imposition of tighter eligibility thresholds meaning large reductions in the numbers of older people who can access state-funded care (Age UK, 2018). This has led to significant unmet care needs. Over the past decade there has been a steady decrease in the numbers of older people (65+) who are receiving care services, with the National Audit Office (2021) reporting that 24% of adults aged over 65 have some unmet need in relation to their

¹⁴ The main source of data referred to in this section is Skills for Care, the employer-led workforce development agency for adult social care in England. It administers the National Minimum Dataset for Social Care (NMDS-SC), which is funded by the Department of Health and Social Care (DHSC) and is the leading source of workforce information on the sector. While the data is detailed and highly useful, care providers submit data voluntarily, therefore it does not represent a full census of the workforce.

daily living activities. These inadequacies in the system place increased burdens on unpaid carers. Estimates suggest high – and increasing – levels of unpaid care across the UK, with one in eight adults (around 6.5 million people) in the UK providing unpaid care (Carers UK, n.d; Carers UK, 2020).

The knock-on effects of inadequate social care on the National Health Service (NHS) are also a critical aspect. The NHS is unable to discharge older people from hospital if care packages cannot be put in place for them at home. The chief executive of the NHS Confederation, the membership body that speaks for the healthcare system as a whole, recently stated that the ‘number one measure’ the government could take to address the unsustainable pressure that the NHS is facing would be to address the significant staff shortages in adult social care (Gregory, 2021:n.p.).

The entire care system in England is frequently described as being ‘in crisis’ (Peng and Yeandle, 2017; Crew, 2021). Public discussion, over several decades, has focused heavily on the need for long-term financial planning and increased funding for the sector (Quilter-Pinner, 2019; National Audit Office, 2021). While the government has repeatedly delayed reforms to social care funding (Stewart et al., 2021), an increase in National Insurance contributions (a form of tax paid on earnings) was finally announced in September 2021 to fund both the NHS and social care sector. However, the health sector’s needs have taken priority and absorbed the majority of the new funding, leaving many disappointed at the

inadequacy of investment in social care given the serious challenges the sector is facing (Rudgewick, 2021; UKHCA, 2021).¹⁵

Many have also emphasised that increasing funding must go hand-in-hand with addressing major systemic flaws (Quilter-Pinner, 2019; Stanley et al., 2021). This includes addressing workforce development, pay and conditions, and the commissioning and service delivery models. One of the central findings of the Scottish Fair Work Convention inquiry into social care was that the commissioning system – with local authorities only willing to pay for the actual amount of time that direct care services are delivered – has ‘created a model of employment that transfers the burden of risk of unpredictable social care demand and cost almost entirely onto the workforce’ (Fair Work Convention, 2019: 8). This is credited with significantly driving down pay and conditions in the sector.

5.2 The care workforce and employment practices

In 2020/21, 1.54 million people worked in the sector, making it a bigger employer than the NHS (Skills for Care, 2021). While a high number of adult social care organisations are classified as micro or small, the largest organisations employ almost half of the care workforce. Women are heavily over-represented in the care workforce (82%) and more likely to be found in direct care than senior management roles. Black, Asian and minority ethnic (BAME) workers are also over-represented (21% of workers) (ibid.).

¹⁵ The new levy will make available an additional £12 billion per year for health and social care, with the government planning to provide £5.4 billion of the new resources to the adult social care sector over the next three years (HM Government, 2021).

The sector is experiencing significant staffing pressures. Though the workforce has been expanding, it is estimated that 6.8% of all job roles in adult social care were vacant at any one time in 2020/21 (105,000 vacancies), a rate that is significantly higher than that recorded in 2012/13 (Skills for Care, 2021) (see Figure 15). While vacancy rates fell at the start of the pandemic, they have started to rise again and the latest monthly rate, recorded in October 2021, reached 11.2% (far above pre-Covid-19 levels) (MAC, 2021). Employers report that recruitment is particularly challenging now that the hospitality and tourism sectors in the UK are operational after a period of sustained lockdown (ibid.). Within the adult social care sector, the vacancy rate is particularly high for registered nurses and care workers (see Figure 16).

Fears grew during 2021 that volunteers would be needed to tackle staff shortages in care homes, as a result of a new requirement that all care-home workers be fully vaccinated against coronavirus (Booth, 2021). The government estimated that up to 12% of care-home workers could leave the workforce after this condition was enforced (from November 2021) (DHSC, 2021d). Some reports suggest around 40,000 workers left their jobs as a result of the vaccine mandate (Learner, 2022). However, the government has since revoked this condition, which was set to be expanded to all health and social care staff from April 2022, given the serious concerns around chronic workforce shortages in both sectors (Ford, 2022).

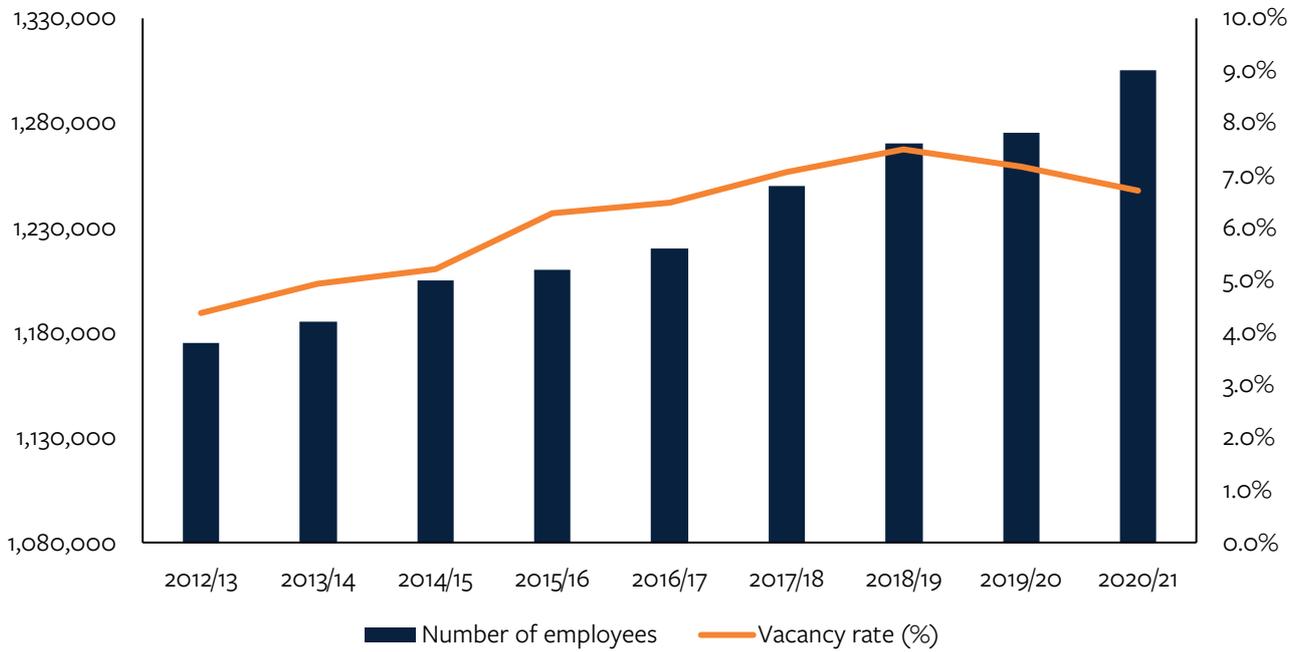
The risk of acute labour shortages is also a serious concern due to the significant demographic challenges that the UK is facing. Current trends suggest both a greater demand for care and increasingly complex care needs in future (National Audit Office, 2018). Skills for Care (2021) forecasts that if the adult social care workforce

grows proportionally to the projected number of people aged 65 and over in the population between 2020 and 2035, an increase of 29% (490,000 extra jobs) would be required by 2035. Other estimates are even higher, with The Health Foundation forecasting that up to 627,000 extra social care staff will be needed by 2030/31, an increase of 55% over 2018/19 levels, and four times greater than the increase in the workforce over the past decade (Rocks et al., 2021). This represents a mammoth challenge.

An array of factors is considered responsible for the high vacancy rates in the sector, including low pay (Skills for Care, 2020; 2021). The median care worker hourly rate recorded in March 2021 in England (£9.01) was just above the nationally mandated minimum wage (£8.72) at that time, making care work among the lowest paid jobs in the UK (Skills for Care, 2021). Overall pay rates are higher for care workers who are employed directly by local authorities compared to the private sector, however only 7% of jobs in the adult social care workforce are with local authority employers (Skills for Care, 2021).

There are also reports of the prevalence of underpayment in the sector, with large numbers of care workers paid below the minimum wage (National Audit Office, 2014; Dromey and Hochlaf, 2018; Low Pay Commission, 2019). Many care workers are also not paid for travel time between the homes of their clients, further eroding earnings (National Audit Office, 2014; UK Home Care Association, 2015). In addition, research has found that some home-care workers subject to electronic monitoring systems are only paid for direct contact time in the home, and only when that contact time matches the official schedule recorded. This has resulted in workers not being paid when care visits over-run (a frequent occurrence), and has further expanded

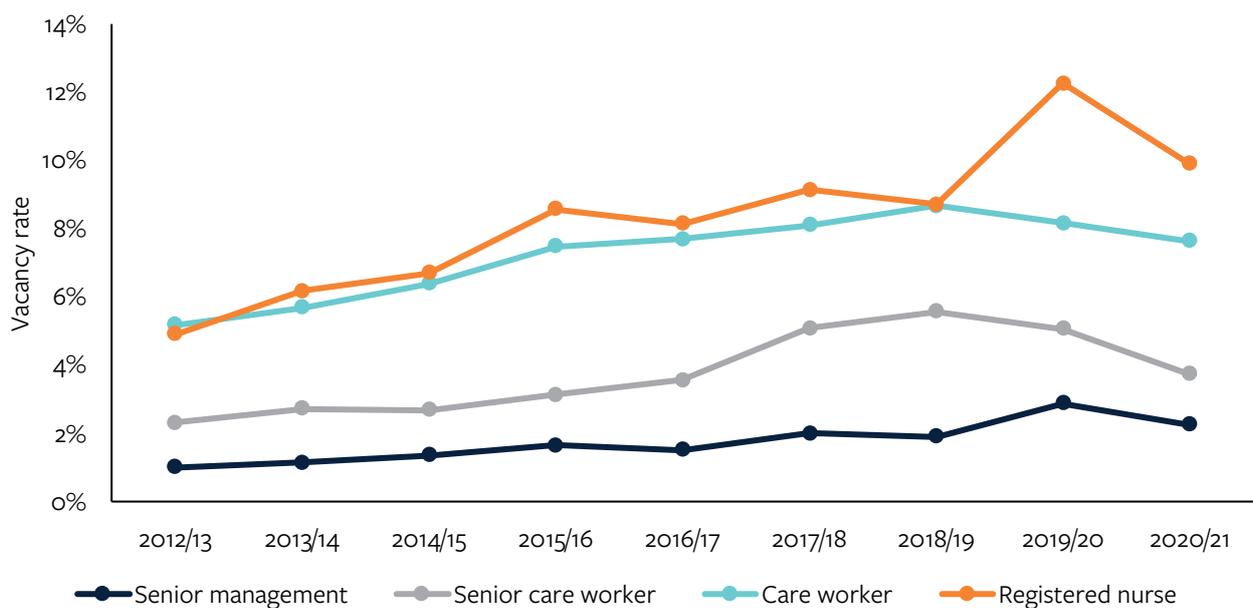
Figure 15 Vacancy rate trend and numbers of employees in the adult social care sector



Note: This information refers to adult social care jobs in the local authority sector and independent sectors only. Employees working for direct payment recipients and those working in the NHS are not included in these workforce estimates. The number of employees shown here is, therefore, smaller than the total workforce figure provided earlier.

Source: Skills for Care, 2021

Figure 16 Trends in vacancy rates across selected professions in the adult social care sector



Source: Skills for Care, 2021

the concept of ‘unpaid working time’ for these workers (Hayes and Moore, 2017). The pandemic has exacerbated problems, with a 2021 longitudinal survey finding 32% of respondents reporting an increased workload without additional pay and revealing additional pressures on an already stretched workforce (Hussein et al., 2021).

A lack of job security, casualisation, lack of adequate training and stressful working conditions have also been commonly identified. Conditions in home care are considered among the most precarious in the British economy (Carers UK, 2018). In particular, the short time slots allocated for home-care visits are frequently highlighted as inadequate to provide dignified care (UNISON, 2017; Stanley et al., 2021). Just under a quarter of the workforce (24%) in the social care sector has been recorded as employed on zero-hour contracts. The share is higher specifically for carers (35%) and jumps alarmingly for those employed in home-care services (55%) (Skills for Care, 2021). This is an ingrained problem for the sector, with the share of workers on zero-hour contracts remaining relatively stable since 2012/13 (see Figure 17). While the UK has a regulator, the Care Quality Commission, its mandate is to monitor care quality standards, not to monitor the workforce and working conditions (CQC, n.d.).

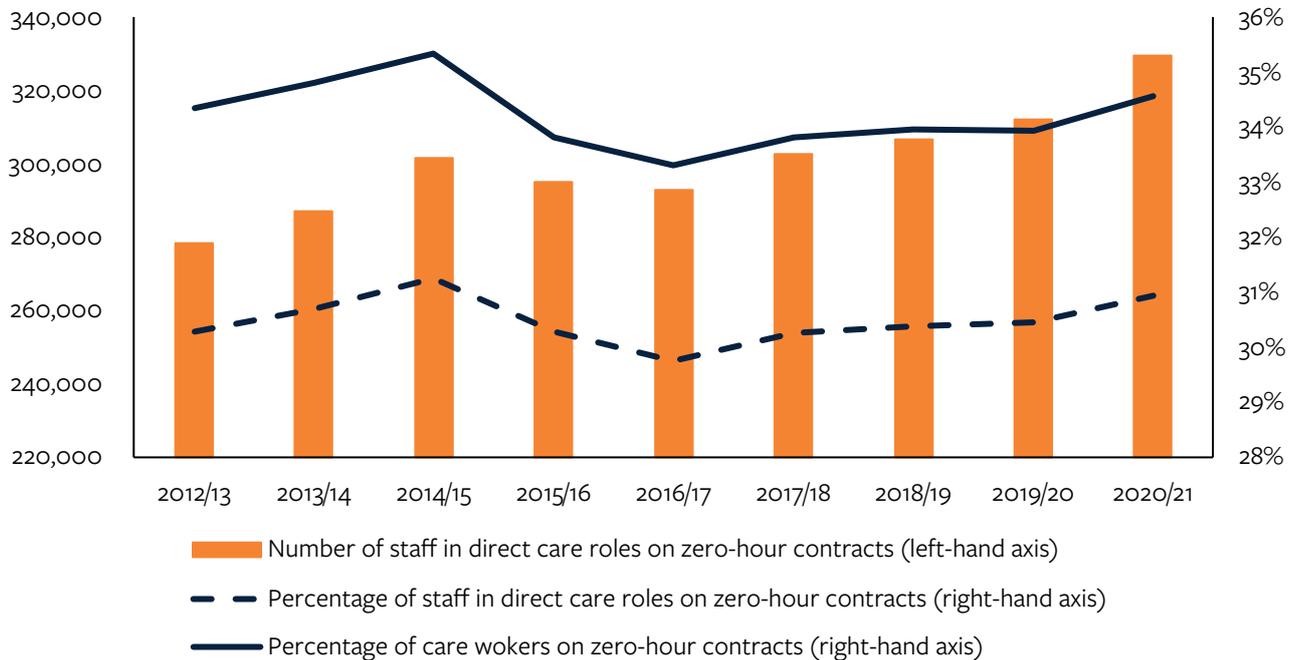
While increased funding is not the silver bullet to solve all challenges in the sector, there is no way to improve pay and conditions without significantly increased funding. Calls for action have focused on improving pay, including payment of a real living wage, equalising pay with NHS levels and for the UK government to establish a new system of sector collective bargaining. (Quilter-Pinner, 2019; Stanley et al., 2021). More ethical commissioning, a recognition of the skills needed to deliver quality care and investment in training and professional

development are also seen as fundamental to a transformational agenda for the sector (Quilter-Pinner, 2019; Scottish Government, 2021c).

5.3 Migrant workers in the care sector

Foreign-born workers made up 22% of the social care workforce in 2020/21. Given that many of these workers go on to acquire British nationality, 16% of the workforce is currently recorded as non-nationals (Skills for Care, 2021). Migrants born outside the European Union account for a greater share of the workforce than migrants born in EU countries – this has been the case for many years (Franklin and Urzi Brancati, 2015; Skills for Care, 2021). However, trends are changing in this area (see Figure 18). The contribution of the migrant workforce varies greatly by region, with London and the southeast of the country particularly reliant on migrant care workers’ contributions. In 2020/21, Romanian and Polish workers were the most commonly recorded non-British nationalities in the adult social care workforce, followed by workers from Nigeria, India and the Philippines. Most migrants are working as care workers (including senior care workers), registered nurses and personal assistants (Skills for Care, 2020).

Research has found that, after accounting for factors such as gender, age and years of experience, migrant workers – particularly non-European migrant workers – are significantly more likely to have higher qualifications, compared to UK-born workers (Franklin and Urzi Brancati, 2015). As well as their higher qualifications, employers have also highlighted other benefits of employing migrant workers, including their reliability, flexibility and that they can pay them lower wages than comparable UK-born workers (ibid.). Migrants report choosing the sector for a variety of reasons including a genuine desire to

Figure 17 Trends in zero-hour contracts for staff working in direct caring roles

Note: This information refers to adult social care jobs in the local authority sector and independent sectors only. It shows those working in direct care roles as well as the specific trends for the ‘care worker’ category. This category does not include senior care workers who are much less likely to work under a zero-hour contract.

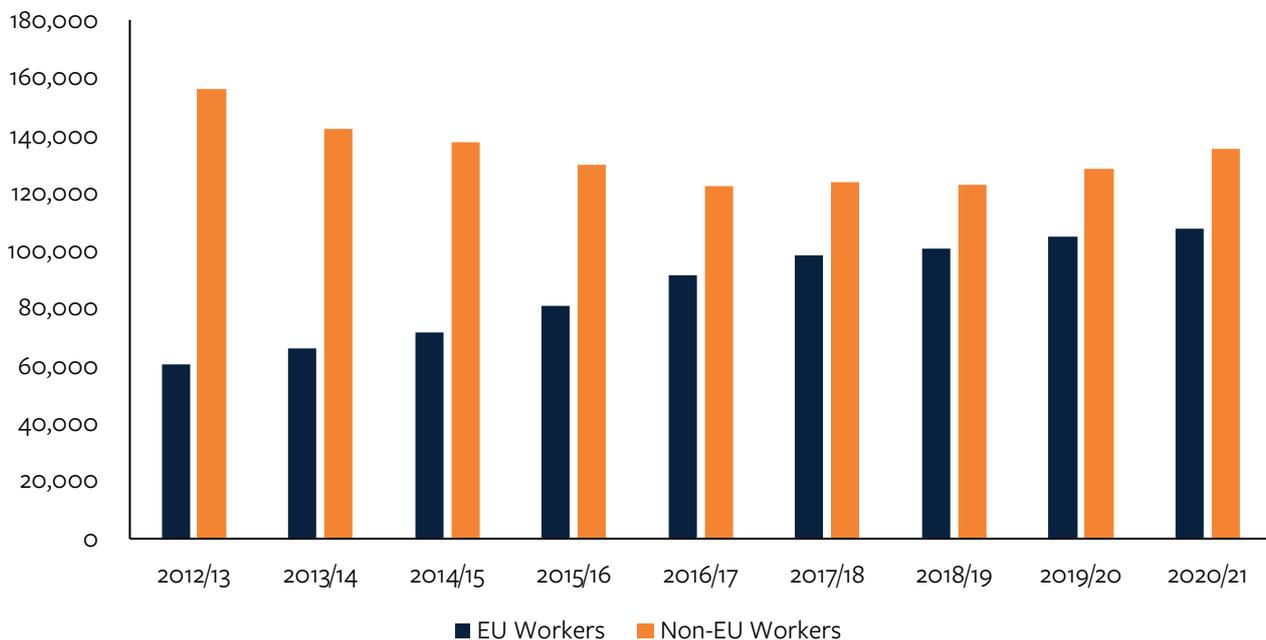
Source: Skills for Care, 2021

help older people, a way of improving their English and a way into the UK job market – likely a key reason given the low barriers of access to adult social care occupations (ibid.). While migrant workers are aware of the disadvantages of working in social care, including its low pay, low status and precarious conditions, for many it is perceived as a useful stepping stone, either towards other jobs in the sector or to move on to other jobs in the UK at a later date (Franklin and Urzi Brancati, 2015; Turnpenny and Hussein, 2021).

The presence of migrants from outside the EU has been affected by a series of immigration reforms, which have limited their chances to be recruited internationally into most adult social care roles. This is visible in the trends of recruitment of care

workers, with numbers of workers from non-EU countries declining and those from the EU increasing (see Figure 18).

This increasing reliance of the sector on workers from the EU is notable and a concern in the context of Brexit. The latest Skills for Care data does not show a ‘Brexit-effect’ across job roles. There have been no reductions in the number of EU nationals employed as care workers, with numbers consistently increasing since 2012/13 and no declines registered since the Brexit referendum. As yet no large impact across the care workforce as a whole has been registered. However, there is a general acceptance that the supply of foreign-born workers will be less available to the sector generally, since new immigration rules came into place in January 2021 (Skills for Care, 2021) and that Brexit, in particular,

Figure 18 Trends in the number of EU and non-EU nationals working in the UK adult social care sector

Source: Skills for Care, 2021

‘is expected to deprive the UK of a non-negligible source of foreign adult social care workers’ (Desiderio, 2021: 9).

Generally, the use of complex commissioning practices, the fragmented organisational arrangements, dominance of private agencies and lack of comprehensive regulatory oversight have all been identified as making the UK social care sector vulnerable to the risks of exploitation and modern slavery (Craig and Clay, 2017; Turnpenny and Hussein, 2021). There have also been fears expressed that a lack of effective legal pathways for most social care roles could lead to increased exploitation of migrant workers in future (Turnpenny and Hussein, 2021). The limited resources to carry out labour inspection and enforcement in the UK have also been noted, adding to concerns in this area (Turnpenny and Hussein, 2018).

5.4 Policy responses to workforce shortages

Efforts to address low pay in the sector include the introduction of the mandatory national minimum wage from April 2016. This includes annual increases and has had a positive impact on pay (Skills for Care, 2020; 2021). However, the substantial underfunding of the sector means employers have struggled to implement wage increases. Most notable is that wage increases in England have occurred in parallel with more care workers being paid at the minimum rate (Skills for Care, 2021). In Scotland, the government has gone further, raising social care workers’ pay to £9.50 per hour in May 2021 and then again to £10.02 per hour in December 2021 (Scottish Government, 2021a; 2021b). This is largely a response to the recommendations made in the independent review of social care (Scottish Government, 2021b). It marks a significant departure from England’s approach; the minimum wage for social

care work in Scotland will be 12.5% higher than England's minimum wage in light of December's change.¹⁶

The UK government has also recently released a policy paper detailing its plans for adult social care reform in England, including a £500 million investment in a workforce strategy over three years (DHSC, 2021c). The strategy aims, among other things, to develop new career structures and training opportunities for the sector. A national knowledge and skills framework is envisaged, alongside the creation of a recognised Care Certificate (ibid.). The government is also making efforts to raise the profile of the sector through a national recruitment campaign launched in 2020 (DHSC, 2021a). One of its main aims is to highlight the critical role that workers have played throughout the pandemic and to inspire people to choose a career in adult social care. It includes a rapid online training programme that interested applicants can access (ibid.).

It is difficult to have confidence that policy responses are having an impact. The Nuffield Trust reported that 42,000 adult social care staff left the sector between April and October 2021 (Crew, 2021). Immigration is therefore an important remaining policy option. However, the UK has enacted progressively more restrictive legislation over the past decade, despite strong public support (77%) for the recruitment of migrant workers into key services such as health and social care (Rolfe et al., 2021). More recent reforms show the government is changing course in this area.

5.5 Immigration policies and the care sector workforce

There has been a long-standing concern that UK work visa schemes have not been able to satisfy demand for migrant workers in the care sector (Franklin and Urzi Brancati, 2015). While the UK has well-established government-to-government health worker agreements, such as with the Philippines and some Indian states, specific legal labour migration pathways to enable migrants to enter the care workforce have only very recently been created. As such, the majority of migrants working in the adult social care sector have been recruited locally and already have the right to work in the country, rather than coming through labour migration channels (Spencer et al., 2010). However, there has historically been some agency recruitment for the social care workforce from outside the UK, including from eastern Europe, and traditional work-permit schemes have been used to attract nurses from India and the Philippines who have come to work as senior care workers in the UK (Hussein et al., 2010).

In 2008, the UK government reformed the immigration system, putting in place a visa system based on tiers. It designed a pathway within this system – Tier 3 – to enable 'low-skilled' workers from outside the European Economic Area (EEA) to come to the UK to work. Yet the tier was not opened because the UK government felt there was no need for 'low-skilled' immigration from outside the EEA in the context of an enlarging EU; the tier was shut down in 2013 (UK Parliament, 2017; Sumption and Fernández-Reino, 2018). The impact of EU enlargement on workforce supply is very visible in the adult social care workforce (see

¹⁶ The UK national minimum wage increased to £8.91 in April 2021. This is compared here to the hourly wage introduced for carers in Scotland in December 2021 (UK Government, n.d.; Scottish Government, 2021a).

Figure 18). In the context of Brexit, employers have become increasingly worried about the continued availability of staff (Read and Fenge, 2018).

Generally, the Migration Advisory Committee (MAC), an independent body that advises the UK government on migration issues, has been hesitant about recommending the use of migration policy to address challenges with the adult social care workforce. The MAC (2020b) has argued for several years now that increased funding, to enable higher wages and make jobs more attractive to the domestic workforce, is the correct and sustainable way to address workforce issues. In particular, the MAC has expressed concern that migration policy may end up being used to create a ‘captive’ workforce of low-paid workers tied to their jobs by visa conditions and at risk of exploitation.

Current rules introduced from January 2021 mean that the primary entry route for all migrant workers is now under the Skilled Worker Route of the Points-Based Immigration System, which includes salary and qualifications thresholds. Occupations designated as ‘shortage occupations’ have a lower salary requirement. While senior care workers were included on the list in March 2021 (Clarke, 2021) most senior care workers’ salaries, according to data up to March 2021, fall beneath the minimum salary threshold, with only those employed directly by local authorities likely to qualify (Skills for Care, 2020). However, there is some evidence of take-up of the scheme, with applications from senior care workers reaching 400 to 500 per month towards the end of 2021 (MAC, 2021).

Following this limited reform, key stakeholders continued to advocate for change. The Cavendish Coalition – a coalition of 37 health and social care organisations including the workforce agency Skills for Care – called for immigration policy to specifically recognise occupations that provide ‘a high public value’ and for the UK government to take ‘all possible measures to safeguard the future supply of health and social care workers needed to continue delivering safe, high-quality care’ (Skills for Care, 2021: 91). A new MAC review highlighted the extremely high vacancy rate, consistently high turnover and the fact that the required funding to address substantial workforce challenges has not materialised (MAC, 2021). Given the scale and immediacy of workforce challenges, they concluded that all adult social care workers, including home-care workers, should be included on the shortage occupation list and be eligible for the Health and Care Worker Visa (ibid.).

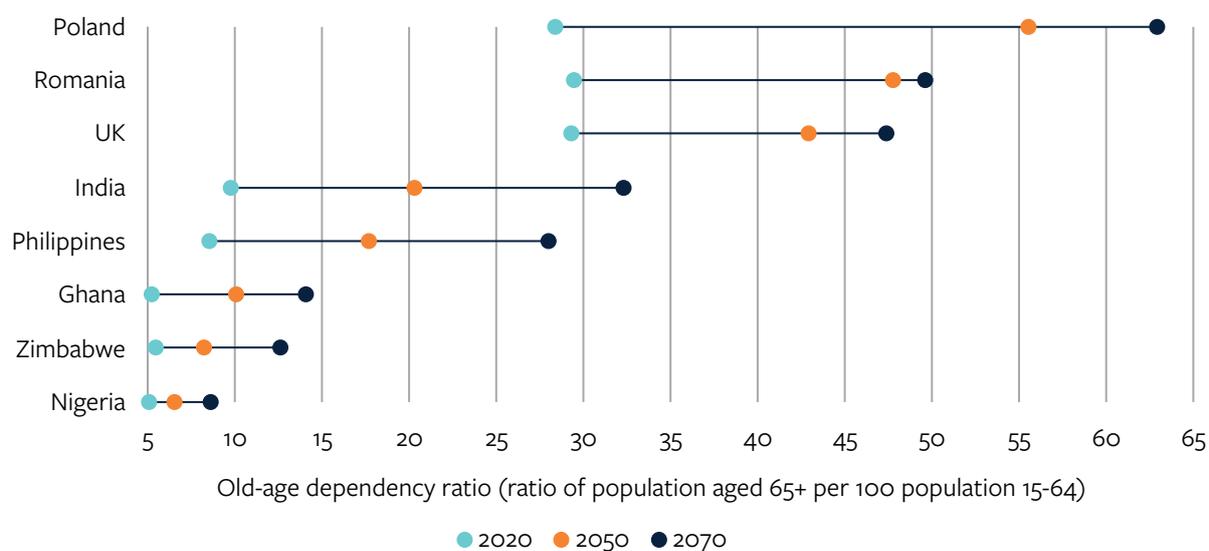
Following this recommendation, the UK government announced in December 2021 that social care workers (including those working in home care) would be added to the shortage occupation list, and be eligible for a 12-month period to apply for the Health and Care Worker Visa (Therrien, 2021). Workers who apply will pay reduced visa fees, can bring their dependents and will benefit from a path to settlement if they remain employed (DHSC, 2021b). However, given the minimum salary requirement, migrant care workers would need to have an annual salary of £20,480 to qualify for this visa. This is likely to be a major barrier to international recruitment, since care workers employed in the private sector – the vast majority of the workforce – earn substantially below this figure.¹⁷

¹⁷ Skills for Care (2021) report £17,900 for the full-time equivalent mean annual pay rate of social care workers in the private sector, compared to £20,700 for those directly employed by local authorities.

Finally, rapid ageing in countries of origin is likely to affect patterns of labour migration for the older persons' care sector in the UK. Rapidly ageing forecasts for Romania and Poland mean that both countries would likely no longer be a significant source of migrant labour for the social care sector, even if free movement with the EU were reinstated in the future. Similarly, India and the Philippines will relatively soon become less sustainable sources of labour. Instead, other countries of origin, such as those shown in Figure 19, are likely to become more important in the years ahead. In particular, there is a need to recognise that countries with younger demographic profiles – such as Ghana, Zimbabwe and Nigeria – are likely to be a more sustainable source of long-term care workers for the UK over the longer term (Adhikari et al., 2021). However, both Ghana and Nigeria are considered 'red list' countries in the UK's *Code of Practice for the Recruitment of International Health and Social Care Personnel in England*, meaning active recruitment of social care workers is prohibited unless government-to-government

agreements are in place (DHSC, 2021e). These are additional considerations that should be taken into account in long-term policy planning (see Section 3 for more discussion of this area).

Figure 19 Ageing trends in the UK compared with a selection of countries of origin



Note: This figure uses UN DESA 'medium variant' projections.

Source: UN DESA Population Division, 2019

6 Country case study: United States (US)

6.1 Overview of the long-term care sector in the US

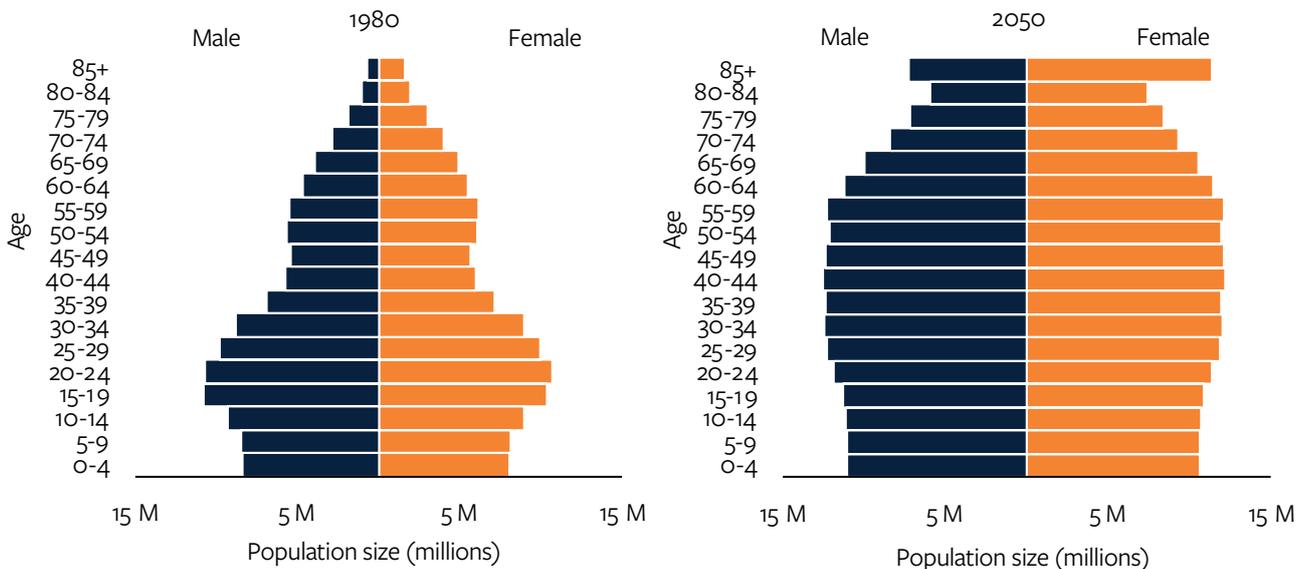
By 2034, older adults are predicted to outnumber children in the US (Vespa, 2018). A rapidly ageing population is a new phenomenon for the country: previously, higher fertility rates and migration helped the US to maintain a younger population than other high-income countries. Whereas the US population in 1980 resembled a pyramid – a large share of children and young people at the bottom waning to a much smaller cohort of older adults at the top – it now resembles more of a pillar (Figure 20). The impact of these major demographic shifts is already looming: by 2025, the first of the ‘baby boomers’ – that 77 million-strong group born between 1946 and 1964 – will reach age 80 (Gleckman, 2020).

In the US, ‘long-term services and supports’ (LTSS) is the term used to describe the ‘broad range of paid and unpaid medical and personal

care assistance an individual may need when they experience difficulty completing self-care tasks as a result of ageing, chronic illness, or a disability’ (Reaves and Musumeci, 2015). LTSS can be provided in the home, in a facility (such as a nursing home), or in the community (such as an adult day care centre, or assisted living facility) (National Institute on Ageing, 2017).

According to the latest figures from the National Center for Health Statistics (NCHS), in 2016 long-term care workers served more than 8.3 million people in five sectors in the US (Harris-Kojetin et al., 2019). This includes adult day care centres, home health agencies (that provide home care services), hospices, nursing homes, and assisted living and residential care communities. Those receiving services from home health agencies make up the majority (at more than 4 million people) with those in the other facilities making up the rest (just under 4 million) (ibid.). In line with trends across other OECD countries, there have

Figure 20 Population pyramid for the US, 1980 and 2050



Source: US Census Bureau (n.d.)

been consistent efforts to rebalance the long-term care sector away from expensive institutional care options towards more home- and community-based care delivery – as such the home-care workforce has seen a rapid expansion in size since 2008 (Campbell et al., 2021).

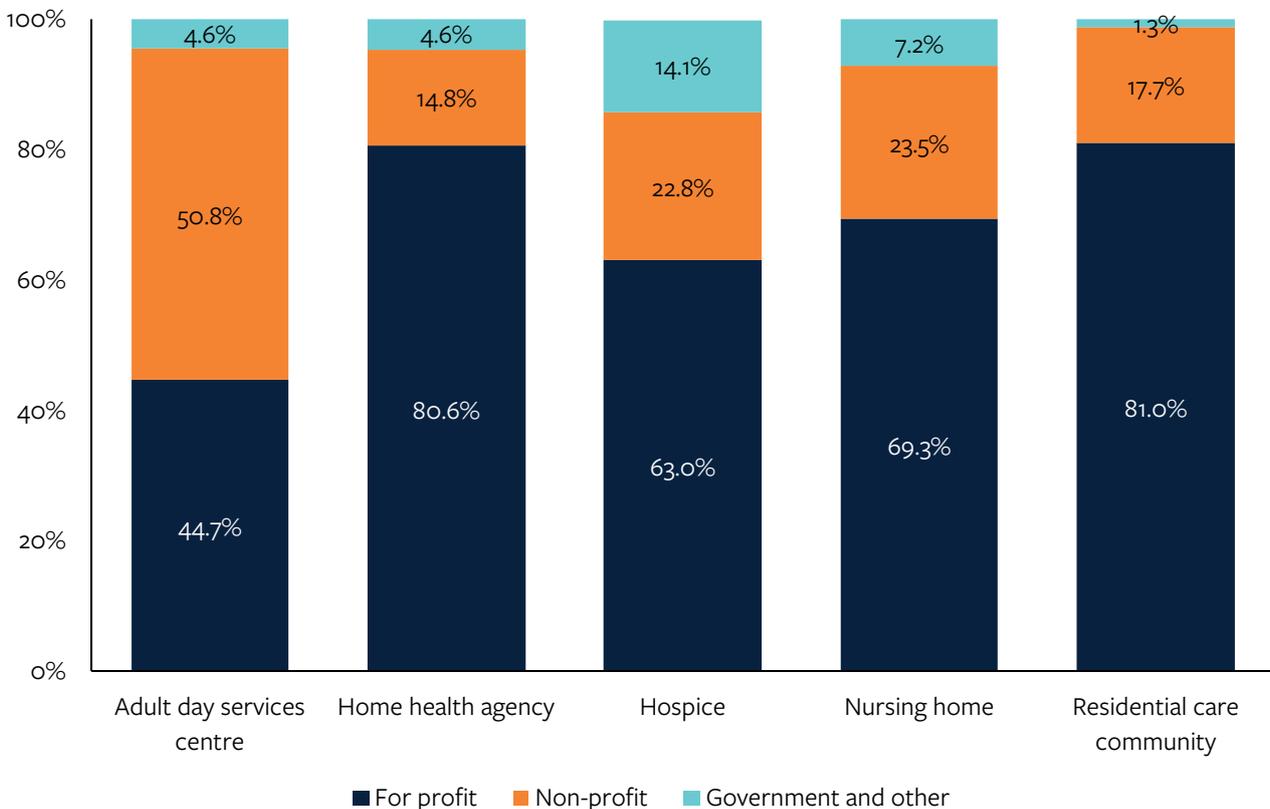
Most long-term care service providers are private and for-profit (see Figure 21), with smaller percentages run by non-profit actors. Though for-profit actors are central to the provision of long-term care, their revenue is highly dependent on public financing. The fact that for-profit providers can be associated with low-quality care has long been a subject of discussion in the US (see Gupta et al., 2021). In particular, the impact of private equity ownership of nursing homes on the quality of care has been investigated (see Section 2 for a discussion of research on this). Also notable is that

the proportion of for-profit providers in owning and operating nursing homes and residential care facilities is much higher than the comparable experience for hospitals, where only around one-third are for-profit (ibid.).

6.2 Accessing long-term care in the US

In the US, there are two health insurance programmes offered by the government: Medicaid and Medicare. Medicaid is a social assistance healthcare programme that serves low-income individuals of any age. It provides coverage for long-term care as the primary public payer in the US. However, it has strict eligibility rules related to both the income and assets of individuals and their extent of need. Though rules vary across states, those who qualify mainly have very low incomes

Figure 21 Long-term care service providers, by sector and ownership, 2016



Source: Harris-Kojetin et al., 2019

and virtually no assets (Johnson, 2019a). Generally, an individual's annual income must fall below the poverty line in the state in which they reside and they must exhaust all of their savings to qualify (Campbell et al., 2021).

Medicaid covers older adults and people with disabilities in various settings such as nursing homes, private homes and community-based services for those with less complex needs (Johnson and Lindner, 2016). Though set up originally to focus on institutional care, states are increasingly trying to rebalance Medicaid expenditure on long-term care by expanding home- and community-based services (HCBS); these now make up the majority (57%) of Medicaid LTSS expenditure (Campbell et al., 2021). Expenditure in this area has been increasing, but the waiting list for qualifying individuals to access Medicaid's HCBS is currently more than 800,000 people and the wait time averages 39 months (Office of US Senator Bob Casey, 2020). Moreover, many people in need of HCBS never seek government support or do not qualify for it, so the level of need is likely to be much higher than the waiting list (Chandler, 2021).

Nearly every individual aged over 65 in the US is eligible and enrolled in Medicare. It is a federal insurance programme that operates uniformly across the country. Individuals are automatically enrolled in parts A and B ('traditional Medicare' which covers hospital insurance and outpatient services and supplies) and can opt into parts C and D ('Medicare Advantage', covering private hospital stays, prescriptions and further treatments). In general, original Medicare (parts A and B) does not cover long-term care needs. However, the government recently added some limited benefits related to home-based care via the Medicare Advantage programme (Gleckman, 2020). Medicare also provides coverage in special

circumstances, such as when an older person requires a short-term nursing home stay for post-acute care or for particularly complex long-term care needs (Campbell et al., 2021).

As of 2020, 66.5% of the US population hold private health insurance, mainly via employer-based insurance (Keisler-Starkey and Bunch, 2021). Employer-based insurance coverage ends when an individual retires, but older people can purchase private health insurance policies in the individual market. However, standard private health insurance plans do not cover long-term care. An additional insurance policy specifically for private long-term care must be taken out to cover these needs. Such plans are expensive, particularly as policies are often taken out at later ages when premiums are higher (Johnson, 2016). Moreover, policies may not cover all conditions and care may not be provided if it is required in relation to certain pre-existing conditions (Painter, 2021).

When private long-term care insurance was first offered in the US in the 1980s, the market grew quickly. In the past two decades, however, it has waned in popularity (Johnson, 2016). The number of policies sold in the individual market fell 83% between 2002 and 2014 (Cohen, 2016) and there are currently only about a dozen companies that still sell private long-term care insurance in the US today (Nordman et al., 2016). In 2014, it was estimated that only 11% of adults aged 65 and over living in community settings had private long-term care insurance, with coverage much higher for non-Hispanic whites (13%) than other groups and highest (25%) for the wealthiest older adults (those with more than \$1 million in household wealth) (Johnson, 2016). Given that private insurance is not seen as offering effective solutions, alternative proposals have been made for new, state-level social insurance mechanisms to address financing and access challenges, with

some experimentation under way in Washington State (Veghte et al., 2019).

For those excluded from financial assistance and without private insurance, the only way to access care is by paying for it out of pocket or to rely on unpaid family carers. Out-of-pocket payments are a significant burden since older persons' care is very expensive. On average, it costs \$53,768 annually for professional long-term care at home and \$105,840 annually for care in a nursing home facility (Genworth, 2021). Johnson (2019a) estimates that, based on their income and assets, two-thirds of older people can only cover two years of paid home care and about 50% can pay for two years in a nursing home facility (with time periods lowered in the case of more severe needs, which imply higher costs).

Unsurprisingly, the lack of access to paid care is high and many end up relying on unpaid, informal family care provided by a relative or loved one who is rarely trained as a caregiver. This is the case even when older people have serious disabilities and complex needs: in 2014, for example, only 52% of older adults classified with severe needs received any paid long-term care support (Johnson, 2019b). There are currently about 41.8 million Americans (16.8% of the population) providing unpaid older persons' care, most often to a direct family member, a significant increase on the 34.2 million unpaid carers recorded in 2015 (AARP and National Alliance for Caregiving, 2020).

As in many countries, the long-term care industry depends significantly on public funding to operate. Payments from public programmes (mostly Medicaid and Medicare) account for around two-thirds of the total annual revenue of the home-care industry (PHI, 2021). Similarly, in nursing

homes, government funding accounts for 75% of revenue for providers (Gupta et al., 2021). Public funding is less relevant for residential care facilities (37% of revenue) because assisted living facilities and care retirement communities are more often privately financed (PHI, 2021). Out-of-pocket payments and private insurance account for a relatively minor share of spending across the LTSS sector (16% and 11% respectively) (Campbell et al., 2021).

There have been decades of debate about the necessary financing and policy reforms to increase access to high-quality care services in the US. These have focused on the expansion of Medicaid, (a heavily politically contested issue), how to increase home-based and community care coverage, how to promote private long-term care insurance (including combined with public insurance) and more recently the potential for the inclusion of long-term care benefits in the Affordable Care Act (Johnson, 2019a; Campbell et al., 2021). In the context of rapid ageing trends, it is becoming clear that policy-makers have left it very late to tackle this problem. It has been argued that the US is 'about to reach a critical, historic tipping point in its need to care for frail older adults' (Gleckman, 2020: n.p). While President Joe Biden's American Jobs Plan (The White House, 2021) sought to deliver significant investment in care infrastructure (including targeted expansion for Medicaid and home- and community-based care services), the Infrastructure Bill was signed into law in November 2021 without the \$400 billion provisions to improve the care sector (Library of Congress, 2021). Democrats in Congress are hoping to address 'human infrastructure' issues in a separate social spending and climate package called 'Build Back Better', but there are currently no concrete plans to vote on such a measure.

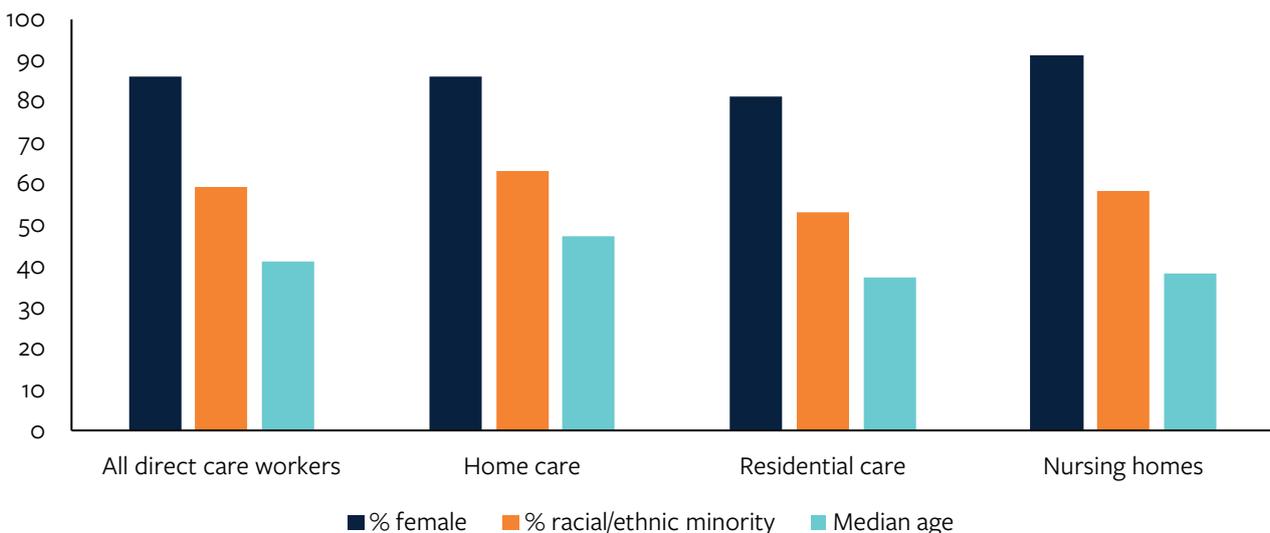
6.3 The care workforce and employment practices

Like other high-income countries, the formal care work sector in the US employs a wide variety of individuals at different levels of skill and qualifications, from registered nurses to health aides (Harris-Kojetin et al., 2019).¹⁸ Most people working within the older persons’ care workforce fall into one of three main categories: home-care workers, residential care aides or nursing assistants. Home-care workers and residential care aides assist those with disabilities and older people with daily living activities like eating, getting dressed and bathing, but their responsibilities can vary widely. Home-care workers assist older people in their own homes while residential care aides are found in various settings, including assisted living facilities and residential care homes. Depending on the state and the employer, direct care workers typically

have the job title of personal care aide, home health aide or nursing assistant. Nursing assistants provide 24-hour care and assistance to residents of nursing homes, helping residents with daily living activities, and performing certain clinical tasks under supervision. For all three of these professions, workers are much more likely to be women and much more likely to be a person of colour compared to the US labour force overall (PHI, 2021; see Figure 22).

In line with the increasing demand for care of an ageing population, the direct care workforce in the US has grown significantly over the past decade, with around 1.5 million jobs added to the workforce (PHI, 2021). It is estimated that there are now around 4.6 million people operating in the direct care workforce in the US, making it ‘larger than any single occupation in the US’ (PHI, 2020:1). Just over half of the direct care workforce (53%) – around 2.4 million people – work in home

Figure 22 Demographic profile of direct care workers



Source: Campbell et al., 2021; PHI, 2021

¹⁸ An aide is a paid staff member who provides direct care and assistance to residents with a broad range of activities; ‘aide’ may refer to certified nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, medication technicians, medication aides and technicians.

care, with much smaller shares of the workforce employed as residential aides (15%) or nursing assistants (12%) (PHI, 2021).

Unlike their counterparts in residential or nursing facilities, home-care workers can be hired directly by individuals or families as ‘independent providers’. Many of these home-care workers will be paid through a variety of publicly funded ‘self-directed’ programmes, through which individuals are given their own budgets to purchase care (Edwards-Orr and Ujvari, 2018). However, others will be paying out of their own pocket to hire independent providers of care. While it is extremely difficult to estimate the total number of independent providers employed as home-care workers in the US, enrolment data from publicly funded, consumer-directed programmes shows that at least 1 million people are employed this way (ibid.). Home-care workers in the ‘grey market’ – those who are paid unofficially – are essentially impossible to count.

Shortages of care workers and high turnover rates are serious, well-recognised challenges across the entire country (Holly, 2019; PHI, 2021). Data in this area is difficult to compile as existing job vacancies are not systematically recorded and there is a lack of robust workforce data collections systems (Campbell et al., 2021). However, understaffing is known to be pervasive in nursing homes with 17% of facilities reporting a shortage of nursing assistants in June 2021, with much higher levels reported during the Covid-19 pandemic (Paulin, 2021; PHI, 2021).

In addition, very high turnover rates have been observed within the home-care industry, reaching a peak in 2018 when the Home Care Benchmarking Study reported that more than half of their agency respondents had to turn away clients due to worker shortages (Holly, 2019). While problems

are pervasive across the care sector, home-care agencies particularly struggle to recruit enough workers given the rapidly increasing demand for their services (Holly, 2020; PHI, 2020). Rural areas appear to be seriously affected by the home-care worker shortages, notably Maine, Washington, Alabama and Montana; other rural states with rapidly ageing populations are expected to experience similar challenges in the coming years (Kosten, 2021). The impact of Covid-19 has exacerbated this challenging situation, with high infection and mortality rates in nursing homes further increasing demand for in-home care for older people (Harootunian et al., 2021). As in other countries, problems with recruitment and retention are widely linked to notoriously low pay, lack of access to employment benefits and poor training and career opportunities (Holly, 2020; Campbell et al., 2021).

The impact of widespread shortages within the sector itself should not be ignored because they are generally associated with an increased workload for existing staff. Nursing assistants, for example, face heavy workloads that require them to support multiple residents simultaneously per shift (on average 13 residents), often with insufficient time to meet the needs of those they care for (PHI, 2021). Demanding workloads and hours lead to stress, injury and burnout, which contributes to high turnover in the field generally. Labour shortages have an impact both on the quality of care and on the prospect of gaining access to care. Staff shortages preventing individuals from gaining access to a nursing-home bed have been documented, particularly during the pandemic (Paulin, 2021). Generally the struggle to recruit and retain enough workers has left older people ‘waiting months or even years to receive formal services’ or ‘simply going without’ (Campbell et al., 2021: 21).

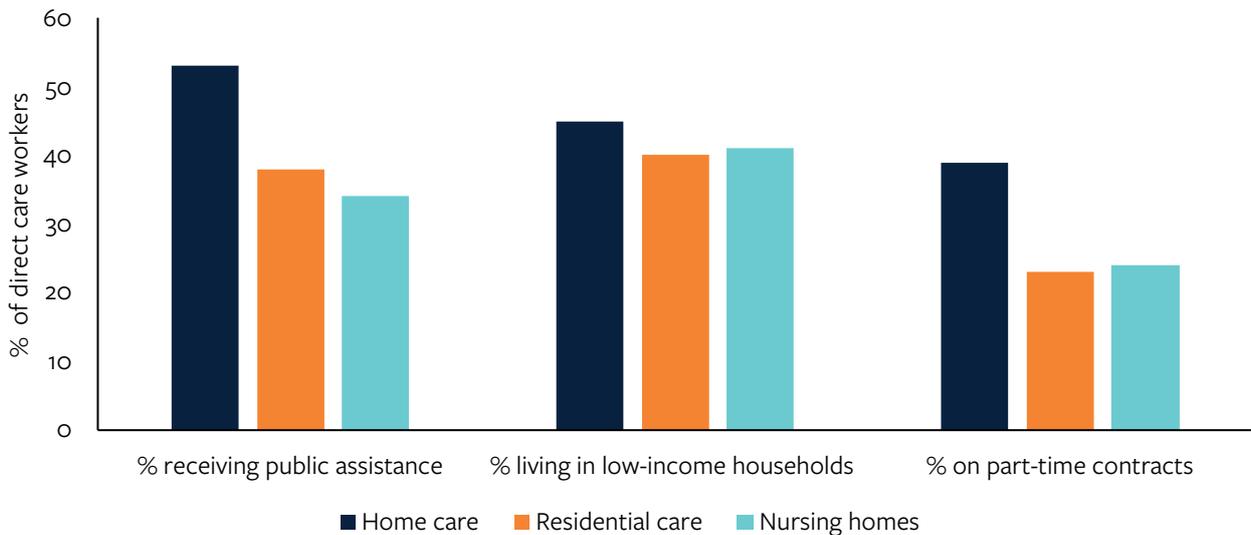
The sector is projected to need an additional 1.3 million direct care jobs by 2029 – ‘more new jobs than any other single occupation’ in the US economy (PHI, 2021: 1). When taking into account workers who retire, exit the labour force, or transfer to other sectors, PHI estimates that long-term care sector employers will need to fill 7.4 million job openings between 2019 and 2029 (ibid.). The growth will mainly be driven by demand for home-care workers and residential care workers and aides in community care settings, as consumer preferences tend to be for home- and community-based services (there is falling demand for nursing assistants who work in nursing homes).

In line with other countries, direct care workers in the US receive very low pay. The average hourly wage for the care workforce was \$13.56 in 2020, although the figure varies widely depending on the state and city (PHI, 2021). High levels of part-time work translate to low annual earnings, with a median annual income of \$20,200 recorded (ibid.). Notable wage disparities exist between direct care workers. For example, white male

home-care workers earn 11% more than women of colour who work in home care (ibid.). Unionised direct care workers have higher wages and are more likely to have health insurance through their employer (Campbell et al., 2021), although very few direct care workers are union members (Bureau of Labor Statistics, 2022).

Low wages, which have seen very little improvement over the past decade, have resulted in financial insecurity for workers; 44% of direct care workers are classified as living in low-income households, with 45% reliant on at least one form of public assistance (such as Medicaid, nutrition assistance, cash assistance) (PHI, 2021). Home-care workers are particularly disadvantaged among care workers generally: they are more likely to have part-time contracts, receive public assistance and live in low-income households (see Figure 23). Low wages are largely driven by low levels of public investment and, in particular, systematic underinvestment in the long-term care sector (Campbell et al., 2021). Given the demographic profile of the workforce (see Figure 22), these high rates of financial

Figure 23 The financial insecurity of direct care workers



Source: PHI, 2021

insecurity particularly affect women of colour and exacerbate long-standing racial and gender inequalities (Espinoza, 2017).

6.4 Migrant workers in the care sector

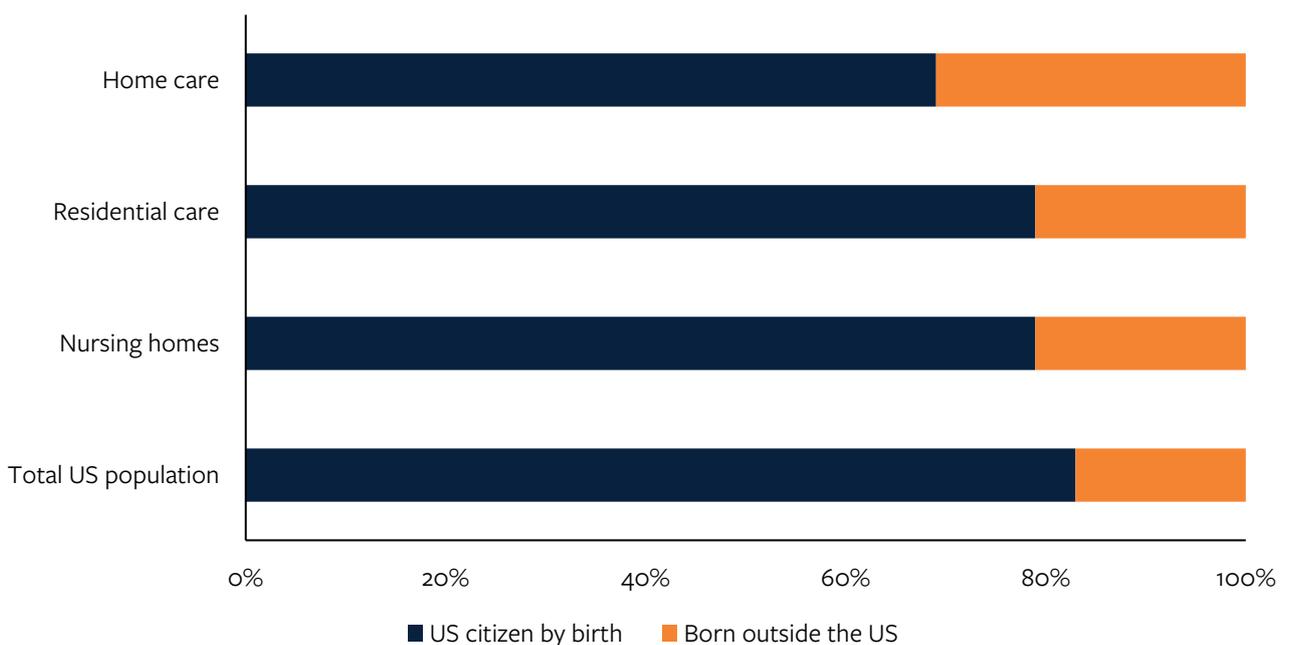
Compared to the overall US population, older persons’ care workers are more likely to be migrants (Zallman et al., 2019; Batalova, 2020). In the US healthcare industry, 18% of all workers are migrants (around 2.6 million workers) (Batalova, 2020). However, the share is notably higher for the long-term care sector, with 26% of all direct care workers being born outside the US and with migrant workers particularly important for home care (31%) (Campbell et al., 2021) (see Figure 24). Additionally, migrants are particularly important in support roles; for example, 30.3% of nursing home housekeeping and maintenance workers are migrants (Zallman et al., 2019). Migrant direct care workers are also more likely to be employed in the informal sector compared with

US-born healthcare workers overall (6.8% versus 4.6%) (ibid.).

The majority of foreign-born healthcare workers are naturalised citizens (69%), though this varies depending on occupation, with the long-term care sector showing much lower rates of naturalisation than those of healthcare workers overall (Batalova, 2020). For example, 79% of registered nurses and 76% of physicians and surgeons are naturalised US citizens, compared to only 51% of home health aides (ibid.). A significant proportion (12%) of migrants who are employed across health and long-term care sector occupations in the US are humanitarian migrants (such as resettled refugees) (ibid.).

Migrant direct care workers are also more likely to be undocumented compared with the population of the US as a whole (4.3% compared to 3.6%) (Zallman et al., 2019). One study even found that 21% of foreign-born home health aides or personal care workers are undocumented (Martin et al,

Figure 24 Direct care workers by place of birth, across settings, 2017 (%)



Source: PHI, 2021 and Campbell et al., 2021

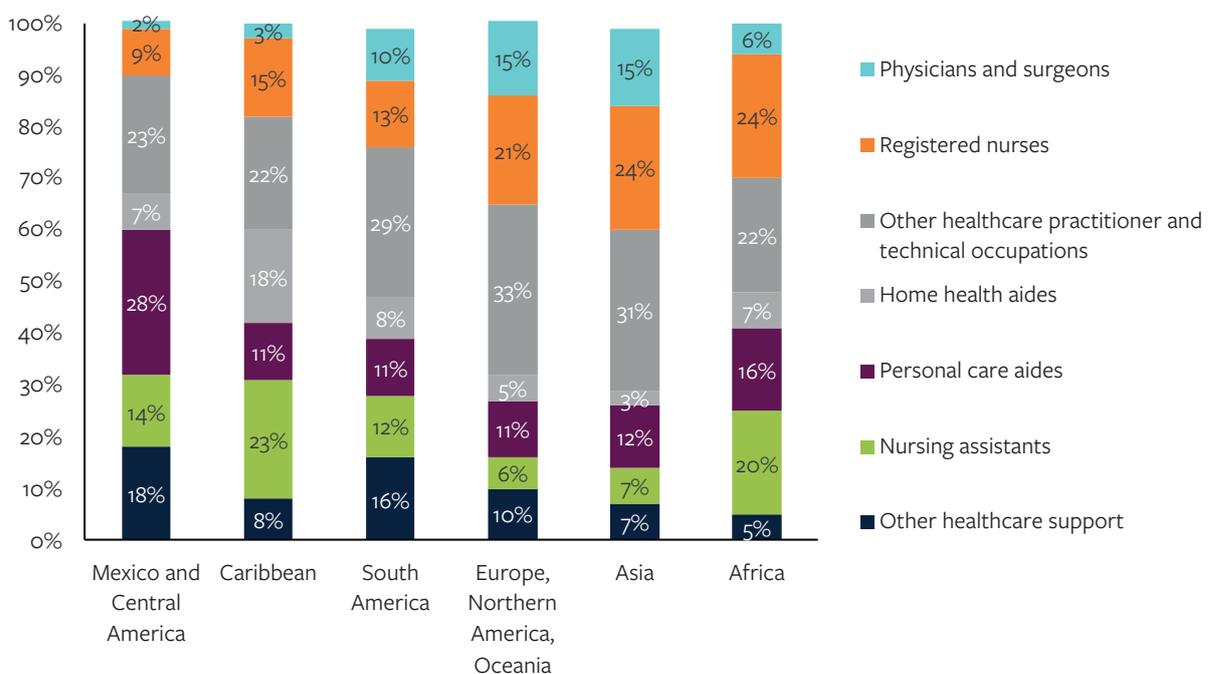
2009). Zallman et al. (2019) found that 43% of undocumented migrant healthcare workers are employed in long-term care settings. Additionally, 13.1% of all housekeeping, construction and maintenance migrant workers in US nursing homes are undocumented (Zallman et al., 2019).

Migrant healthcare workers are more likely than US-born workers to pursue careers as nursing assistants, personal care aides and home health aides (Batalova, 2020). As shown in Figure 25, migrant workers from Mexico, Central America and the Caribbean, South America and Africa are more likely to be employed in healthcare support occupations than as physicians, surgeons or registered nurses (with the exception of those migrating from Africa, who are likely to be employed as registered nurses) (ibid.). The most prominent origin countries for home health aides in the US are the Dominican Republic, Mexico, Jamaica, China/Hong Kong and Haiti. For personal

care aides, the most prominent countries of origin are Mexico, the Philippines and China/Hong Kong (ibid.).

Compared to US-born healthcare workers, migrant healthcare workers tend to be older, less likely to be women, more likely to be Hispanic, non-Hispanic Asian, or non-Hispanic Black, and less likely to have private health insurance (Zallman et al., 2019). Across all occupational roles, migrant workers are more likely to have college degrees than US-born workers, but a fairly large share (for example, 59% of home health aides) are not proficient in English, limiting their employment opportunities (Batalova, 2020). While nursing homes have noted the challenges created by language differences, this does not necessarily affect care quality, as illustrated by a study across Washington State (Acker et al., 2014). It recorded 75% of facilities reporting problems with language differences, but at the same time

Figure 25 Migrant healthcare workers (age 16 and older), by region of birth and occupational group, 2018



Note: MPI tabulation of data from the US Census Bureau 2018 ACS
 Source: Batalova, 2020

that the share of migrant workers was positively associated with independent quality ratings for nursing home facilities across the state (ibid.).

Migrant health workers' experiences of discriminatory treatment, such as in shift assignments, have been well documented (among them, registered nurses, midwives, physicians and other health professionals) (Pittman et al., 2014; Commodore Mensah et al., 2021). In relation to migrant workers across the variety of direct care roles, less research is available on whether they experience differential treatment in the workforce. However, a number of studies have been conducted looking specifically at the experience of nursing assistants working in nursing home settings. A recent literature review concluded that 'social-based discrimination is embedded in the nursing home environment and influences inequitable treatment of direct care staff' (Travers et al., 2020; n.p.). Foreign-born nursing assistants were commonly victims of racism and discrimination (with a general lack of efforts to support staff who are mistreated). Nursing assistants who were migrants commonly experienced higher rates of racial discrimination compared to racial/ethnic minorities born in the US (ibid.).

6.5 Immigration policies and the care sector workforce

Between 1990 and 2007, the number of 'low-skilled' migrants rose from 8.5 million to 17.8 million (Hanson et al., 2017).¹⁹ However, since the global financial crisis, the net inflows of 'low-skilled' migrant labour from abroad have slowed. Between 2007 and 2014, the undocumented migrant population in the US fell in net terms by an annual average of 160,000 individuals, and the

overall population of 'low-skilled' working-age migrants remained stable (ibid.). The reduction in 'low-skilled' migration to the US is a result of several factors, the most critical of which are the marked declines in fertility from major migrant-sending countries in the western hemisphere, resulting in smaller cohorts coming of working age in the 2000s and a weakened demographic 'push factor' to migrate (ibid.). It should be noted that the backdrop to this trend is the slower population growth in the US since the mid-2010s, with birth rates and migration both in overall decline, a trend amplified by the Covid-19 pandemic (Rogers, 2021). The combined impact of these trends on rural areas has been particularly noted, leading to proposals for a 'heartland visa' system to help revitalise struggling rural communities (Ozimek et al., 2020).

Recent years have also seen several hostile immigration policies, including former President Donald Trump's 'travel ban', the elimination of temporary protected status (TPS), and the lowering of the refugee admissions ceiling – these have affected the potential pipeline of direct care workers (Campbell et al., 2021). President Biden has acted to reverse several migration restrictions, including increasing refugee admissions, staying deportations for undocumented migrants who came to the US as children, and not enforcing the 'public charge' rule that denies green cards to migrants who might use public benefits (Krogstag and Gonzalez-Barrera, 2022). Biden has also proposed legislation that would increase the number of employment-based permanent visas – 'green cards' – and allow for spouses and children of green card holders to receive green cards without them counting against the annual cap; this would help to clear the massive backlog of applicants (ibid.). The legislation would also

¹⁹ Hanson et al. define 'low-skilled migrants' as working age migrants with 12 or fewer years of schooling.

eliminate the current per-country cap, which states that migrants from any single given country cannot account for more than 7% of green cards issued each year (ibid.). At the time of publication of this report, this proposed legislation is still being considered by the US Senate and has not been made law.

Despite the existing reliance on migrant direct care workers, the current immigration system does not include any temporary or permanent visa programmes for low-paid care workers. There are only 5,000 green cards available to ‘low-paid’ workers per year, an extremely limited supply that leads to long administrative backlogs and wait times for migrants (ibid.). Currently, the foreign-born healthcare workforce enters the US under a variety of temporary and permanent visa categories (Batalova, 2020). However, aside from family reunification, these pathways are exclusive to physicians, surgeons, and other professionals with advanced degrees and specific skills. There is currently no employment-based visa category accessible to home health aides, personal care aides, nursing assistants, or other individuals in healthcare support roles. In addition, none of these occupations are included on ‘Schedule A’ – the shortage occupation list maintained by the US Department of Labor – which specifies the occupations for which there are not enough US workers who are able, willing, qualified and available (US Citizenship and Immigration Services, n.d.).

Natural and politically motivated reductions in ‘low-skilled’ migration and the lack of options for entry of long-term care workers are together impeding a comprehensive response to workforce shortages and the increasing demand for care.

Zallman et al. (2019: 924) find that given ‘growing demand for direct care workers and immigrants’ already disproportionate role in filling such jobs, policies that curtail immigration are likely to compromise the availability of care’. Moreover, the study states that ‘anti-immigrant rhetoric and policies that restrict immigration threaten the health and well-being of immigrants who are entrusted with the care of the nation’s elderly and disabled people’.

The impact of immigration policy on the quality of care is a particularly important question in light of major shortages and the challenges with affordability and access to care. Emerging research has looked more closely at this issue and found a causal relationship between migration and the use of institutional care facilities in the US: a 10-percentage point increase in the less-educated foreign-born labour force share in a local area reduces the institutionalisation rate for those aged 65 and over by 1.5 percentage points (implying a reduction of 29% in the rate of institutionalisation) (Butcher et al., 2021). The impact is even greater for those aged over 80. In addition to enabling older people to stay in their own homes for longer – an option often in line with the majority of older people’s preferences – increased migration would support the government’s strategic aims to reduce the reliance on institutional care and the cost burden of long-term care provision. Other research has shown that more migrant labour is associated with improvements in the quality of care in nursing homes, pointing also to further benefits of migration policy reform in this area (Furtado and Ortega, 2020).

Many argue that comprehensive migration reform in the US should include the creation of specific

immigrant and non-immigrant visa categories²⁰ that attract and retain migrant home health aides, personal care aides and nursing assistants (Kosten, 2021). Designing migration policies that will help to address the shortage of home-care workers in rural areas has also been noted as being of particular importance given the huge labour shortages experienced in rural communities (New American Economy, 2016; Kosten, 2021). Strong worker protections must be woven into these policies to prevent the exploitation of migrants by employers and individuals who dictate their immigration status. It has also been noted that immigration will be required even if wages for direct care workers increase – evidence suggests that wage rises for home health aides across several states have achieved little in terms of attracting workers and that shortages remain significant (New American Economy, 2016).

Various commentators have made specific proposals as to how migration policies could best fit the needs of the long-term care sector in the US. The first is the creation of a non-immigrant employment-based visa for home health aides, providing a temporary work permit to people working in the older persons' care sector. This would prioritise those who emigrate to rural, medically underserved areas and those most affected by labour shortages (New American Economy, 2016). The second is amending the 'Schedule A' shortage occupation list to include home health aides (ibid.). Currently, registered nurses and physical therapists are the only two healthcare occupations on the list. However, Schedule A is updated very infrequently (and was last amended in 2005) and the US Department of Labor has expressed concerns about the lack of accurate data (Kosten, 2021) – an additional

factor that highlights the importance of creating systems to gather robust workforce data for the long-term care sector. Finally, it is proposed that Congress should create new immigrant status opportunities for home care workers, potentially via a special employment-based visa category (ibid.). Implementing these proposals would quickly and efficiently provide both temporary and permanent migration opportunities to new migrants and contribute significantly to addressing the workforce crisis in the country.

20 A non-immigrant visa category allows people to come to the US for temporary periods, while an immigrant visa allows an individual to come and remain in the US as a permanent resident.

7 The way forward

7.1 Lessons learned

It is apparent from the care and migration literature reviewed, and from the China, UK and US case studies, that migration policy has poorly served the older persons' care sector – both with regard to those receiving care and those providing it. Targeted labour migration policies that effectively serve the sector's needs are rare; where these do exist they have largely failed to deliver the number of workers required and support them through fair pay and labour protections. A number of lessons, detailed below, emerge from these experiences that are of importance when considering migration policy as a solution to older persons' care workforce shortages.

- Free movement arrangements, especially those in Europe, have facilitated the availability of much-needed workers. However, free movement, combined with underdeveloped formal systems of care and a preference for cash allowances for families, appears to have also contributed to a large informal market for older persons' care in some countries. Efforts to monitor this workforce to enforce labour protections and ensure care quality are weak, with particular implications for migrant workers.
- The situation of 'live-in' migrant caregivers stands out. They are frequently subject to abuse; this was one of the main reasons for the discontinuation of Canada's 'Live-in Caregiver Program'. Also vulnerable are migrants who are undocumented or otherwise have an irregular migration status. Providing a pathway to residency, as with Canada's new 'Home Support Worker Pilot', may mean that people move out of the sector once they obtain that status, but their rights are more likely to be upheld in the interim.
- As demonstrated by the UK example, making immigration policies *more* restrictive can have direct negative implications for the older persons' care sector; workforce shortages can rapidly spiral into crisis situations.
- Occupation-specific routes are easier to create as they are linked to clear employer demand. But they can sit awkwardly with existing systems and are often subject to change. Adapting general migration routes (usually a more permanent solution) may be more useful for older persons' care given the long-term nature of the challenge that high-income countries are facing.
- The use of temporary visas for the older persons' care sector creates particular vulnerabilities for migrant workers and also has other negative impacts, creating what could be termed a 'triple loss' situation: (1) a loss of skills and increased turnover in a sector already debilitated by turnover and retention challenges; (2) negative impacts on the well-being of migrants and their families; and (3) poor continuity of care, directly affecting the experience of the older people who are receiving care services.
- Concerns about 'care drain' are relevant when considering the recruitment of older persons' care workers, especially for rapidly ageing countries of origin. Very few countries are addressing how to ensure the ethical and sustainable migration of older persons' care

workers. New partnerships and migration programmes – and new thinking around the training, skills and certification systems necessary to support these – are urgently required.

- The existence of robust workforce data is critical for workforce planning and to inform immigration policies. In the UK, good quality data has facilitated analysis of the sector’s challenges and influenced the decision to include all long-term care workers on the shortage occupation list. By comparison, the lack of accurate workforce data for the long-term care sector in the US remains a barrier to similar moves by the Department of Labor.

A final overarching lesson concerns the long-standing dichotomy between ‘high-skilled’ and ‘low-skilled’ workers that generally underpins migration policy preferences. The persistence in providing migrants deemed as ‘higher-skilled’ with more rights and status and limiting access to those seen as ‘low-skilled’ is neither new nor exclusive to the older persons’ care sector (Cepla and Dempster, 2021). But it has had significant impacts. It also contributes to the workforce remaining undervalued and poorly paid. If high-income countries want to attract migrant workers to the older persons’ care sector, they must detach immigration policies from these inflexible classifications.

7.2 Conclusion and recommendations

Paid care work in the older persons’ care sector remains hugely undervalued, no doubt linked to the feminisation of care work and overwhelming prevalence of women in all care employment. Yet this is a sector with high public value, charged with looking after some of the most vulnerable members of society. As high-income (and other) countries rapidly age, increasing demand and

more complex needs mean the profession of caregiving will become even more demanding. We need a rapid re-evaluation of how the older persons’ care sector is valued and the nature of public policy responses required to tackle low pay and poor working conditions prevalent in the sector. As illustrated throughout this report, the labour shortages in many countries are already serious. The future looks bleak unless there is a monumental transformation in the way we recruit, reward and retain care workers in the next decade.

Migrant workers are already essential to the delivery of care services in many countries, though they are often employed in poor conditions, particularly if undocumented or otherwise operating with an irregular immigration status. OECD countries have developed a heavy reliance on workers from some traditional migrant origin countries. However, these countries are growing economically and also have rapidly ageing populations. The implications of these broader trends are too rarely discussed, but they may make recruitment from certain countries much more difficult in future. At the same time, it is clear that the care sector has few examples worldwide of effective migration pathways that provide sufficient numbers of workers, working under fair employment conditions and delivering quality care. The application of the WHO Code to older persons’ care work also remains a neglected area but should be a focus of attention for the global public health community and development partners over coming decades.

Recognising that much attention has already been devoted to the investments and reforms needed to improve broader care systems, including for older persons, we offer new recommendations narrowly focused on harnessing migration channels and supporting migrant workers as a critical means of strengthening care services for

older people. The recommendations we propose below are intended to complement, rather than replace, broader reforms and investments to strengthen the older persons' care sector in high-income countries, including those reforms and investments that will attract and support local talent. The recommendations apply to policy-makers across countries of destination, though we recognise that more specific strategies are needed for each country based on context-specific existing policies and systems.

Policy-makers in countries of destination should do the following:

- **Make it easier for older persons' care workers to migrate**, through both general migration schemes and targeted pilots. These migration policies could provide either long-term temporary (e.g. three-year) visas – with a view to encourage circularity and skills-building – or a pathway to permanent residency and citizenship.
- **Ensure migration pathways provide a tangible benefit to the country of origin.** As the discussion on the WHO Code illustrates, the migration of older persons' care workers should take place through a bilateral government-to-government agreement that prioritises 'mutual benefit'. Financial and technical assistance can address immediate priorities and could, if well targeted, contribute to the establishment of sustainable and comprehensive long-term care systems in countries of origin.
- **Ensure visas include family accompaniment.** Migrant workers should not be expected to leave their families at home, especially if the visa is long-term temporary or permanent. Excluding family accompaniment merely contributes to the 'care drain'.
- **Ensure visas are not tied to one employer** given the well-documented risks of exploitation and abuse of workers under tied arrangements. Instead, countries of destination could consider occupation-tied visas. For example, a new migrant must work in the *care sector* (as broadly defined) for the length of their visa (at least until they obtain permanent residency).
- **Ensure that migrant care workers benefit from the same range of entitlements as non-migrant care workers.** This must include those working in home-based care and as domestic workers who must also access full labour and social protections. Creating dedicated agencies to monitor home-based working conditions is likely to be necessary in many country contexts to deliver improvements in this area, particularly given that regulation and inspection currently focus mainly on care quality standards.
- **Ensure that migrant workers in the older persons' care sector have access to the same training and skills-upgrading opportunities.** Countries should explore creating a continuum showing the level of skills required for different types of older persons' care workers, and the training required for each level. Migrant and local workers should sit within this continuum and have the ability to move up if desired.
- **Strengthen qualification recognition and ensure harmonisation with countries of origin.** Recognised qualifications and career enhancement pathways are essential for the professionalisation and improvement of the older persons' care workforce in high-income countries. These systems must also ensure that migrants can have their skills recognised. This will prevent 'down-skilling', or the fact that many qualified nurses are working as carers because they cannot get their nursing qualifications recognised. Harmonising these qualification

requirements with countries of origin, perhaps as part of a government-to-government migration agreement, will make it easier for graduates to pursue work in the older persons' care sector at home and abroad.

- **Gather, and publish regularly, data on the older persons' care workforce that includes disaggregated information on the workforce** (gender, age, country of nationality/birth, educational qualifications, skills/certifications), as well as on turnover, retention, vacancies, contract types, pay and conditions. These efforts could be led by a centralised workforce planning unit, perhaps within the Ministry of Health, with this data used to inform the balance between local and international recruitment strategies.

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