Immigration And The Elderly: Foreign-Born Workers In Long-Term Care

by Walter N. Leutz for the Immigration Policy Center

EXECUTIVE SUMMARY

Aging populations and the growing need to provide long-term care to the elderly are among the leading demographic, political, and social challenges facing industrialized countries like the United States. As of 2004, 34.7 million people in this country had lived to their 65th birthday or beyond, accounting for about 12 percent of the US population. Nearly 90 percent of the elderly population is native-born. By 2030, the number of older people in the United States is likely to reach 72 million —or nearly one out of every five people. The aging of larger numbers of Americans will require significant increases in financial and human resources for healthcare support and other social services. As a result, immigrants will continue to play a significant role in the growth of the US labor force in general and the direct-care workforce in particular. It is in the best interests of long-term care clients, providers, and workers if governments and private donors foster training and placement programs rather than leaving the future of the direct-care industry to chance.

Among the findings of this report:

- The 65+ share of the population grew from 4.1 percent in 1900 to 8.1 percent in 1950 to 12.4 percent in 2000, and is projected to reach 19.6 percent by 2030. In absolute terms, the 65+ population is projected to increase from 35.0 million in 2000 to 71.5 million in 2030.
- In 2000, 4.6 million elders, or 4.5 percent of the 65+ population, resided in nursing homes. The group that is most likely to require formal care—those age 85 and over—is projected to increase from 4.7 million in 2003 to 9.6 million in 2030 to 20.9 million in 2050.
- The Bureau of Labor Statistics projects that the longterm care workforce will grow from 2.8 million to 3.7 million workers between 2004 and 2014. After large numbers of baby boomers start to turn 85 around 2030, employment of direct-care workers will grow to about 6 million in 2050.
- In 2005, there were 2.5 million direct-care workers age 18 and above in the US labor force, accounting for almost 2 percent of all employed persons. Three quarters worked in nursing, psychiatric, and home-health jobs. One in five was born abroad. Nearly nine in ten were women.
- US immigration law provides virtually no opportunities for foreign paraprofessionals to work in the United States on a temporary basis or to come here as permanent immigrants. There are no temporary visas designed for direct-care workers and the number of immigrant visas available for all less-skilled workers is capped at only 5,000 per year.

INTRODUCTION

Aging populations and the growing need to provide long-term care to the elderly are among the leading demographic, political, and social challenges facing industrialized countries, including the United States. As of 2004, 34.7 million people in this country had lived to their 65th birthday or beyond, accounting for about 12 percent of the US population.[1] Nearly 90 percent of the elderly population is native-born. By 2030, the number of older people in the United States is likely to double, reaching 72 million—or nearly one out of every five people.[2] moreover, the elderly population is living longer and longer thanks to medical advances and healthier diets. Since old age is associated with disabilities and chronic illnesses such as cancer, diabetes, and Alzheimer's disease, the aging of larger numbers of Americans will require significant increases in financial and human resources for healthcare support and other social services.

However, the US healthcare industry already is experiencing recurring labor shortages, particularly in less-skilled occupations, due to an insufficient supply of workers with the right educational backgrounds, as well as difficulties in retaining existing workers. to fill this gap, immigrant workers have become an integral and growing component of the US long-term care workforce, just as they have in other industries ranging from agriculture to computer science. however, surprisingly little research has been done on exactly how immigrants fit into the occupational hierarchy within the long-term care industry. The direct-care industry encompasses the following three occupational groups:[3]

- **Nursing aides, orderlies, and attendants** who provide basic patient care in nursing facilities and other settings under the direction of nursing staff, such as feeding, bathing, dressing, grooming, moving patients, and changing linens.
- **Home health aides** who provide routine personal healthcare such as bathing, dressing, or grooming to elderly, convalescent, or disabled persons at the patient's home or in a residential care facility.
- **Personal and home care aides** who assist elderly or disabled adults with daily living activities at patients' homes or in daytime non-residential facilities. duties include keeping house, preparing meals, and performing supervised activities.

Although wages for direct-care jobs are low, these jobs are not dead-end and poorly paid *by nature*. An examination of three promising models for the training, placement, and promotion of immigrant workers engaged in longterm care in the United States demonstrates that working conditions and quality of care in direct-care jobs can be improved; that these jobs can serve as stepping stones for moving up in the expanding healthcare field; and that problems with high job turnover can be addressed effectively.

LABOR SHORTAGES IN LONG-TERM CARE

As birth rates fall and life expectancies rise in the united States, the number of "elderly" individuals—those who are 65 and older—is growing rapidly. The 65+ share of the population grew from 4.1 percent in 1900 to 8.1 percent in 1950 to 12.4 percent in 2000, and is projected to reach 19.6 percent by 2030. In absolute terms, the 65+ population is

projected to increase from 35.0 million in 2000 to 71.5 million in 2030.[4]

Significant proportions of the elderly need care. In 2000, 4.6 million elders, or 4.5 percent of the 65+ population, resided in nursing homes. The group that is most likely to require formal care—those age 85 and over—is projected to increase from 4.7 million in 2003 to 9.6 million in 2030 to 20.9 million in 2050.[5] The increasing size of the elderly population is already straining healthcare and long-term care services and increasing the demand for trained staff to provide these services.

At the same time their numbers are increasing, the elderly in the United States also are becoming more diverse in terms of their ethnicities and national origins. Post-World War II immigration from Asia, Latin America, and Africa has been one of the driving forces behind the changing racial and ethnic makeup of the older population. Between 1990 and 2003, the proportion of elders who were foreign- born increased from 8.6 percent to 10.8 percent.[6] As immigrants and their children grow older, their economic needs, cultural values, and linguistic preferences are likely to spur changes in the programs and services that are provided for elderly Americans.[7]

The Bureau of Labor Statistics projects that the longterm care workforce will grow from 2.8 million to 3.7 million workers between 2004 and 2014—an increase of 34.7 percent. This is nearly three times higher than the projected growth rate of the US labor force as a whole (13 percent) and is greater than anticipated job growth in higher-SKILLed healthcare practitioner and technical occupations (25.8 percent). The largest increase in employment (56 percent) is projected among home health aides (Figure 1).[8] If these trends persist, between 3.0 percent and 7.3 percent of the US labor force will be employed in longterm care by 2050—up from 1.3 percent in 2000. After large numbers of baby boomers start to turn 85 around 2030, employment of direct-care workers will grow to about 6 million in 2050.[9]

Figure 1:

PROJECTED EMPLOYMENT IN DIRECT-CARE OCCUPATIONS, 2004-2014

	Total Employment		Increase, 2004–14	
	2004	2014	Number	Percent
Nursing Aides, Orderlies & Attendants	1,455,000	1,781,000	326,000	22.3%
Home Health Aides	624,000	974,000	351,000	56.0%
Personal & Home Care Aides	701,000	988,000	287,000	41.0%
Total	*2,780,000*	*3,743,000*	*964,000*	*34.7%*

Source: Daniel E. Hecker, "Occupational Employment Projections to 2014," *Monthly Labor Review* 128(11), November 2005: 77.

The projected employment growth in direct-care occupations reflects not only the increasing number of older persons in need of care, but also high turnover in the direct-

care workforce. direct-care jobs tend to be physically and emotionally demanding, yet are low-paid and, in many cases, provide few benefits such as health insurance, retirement plans, or child care.[10] In 2000, the median hourly wage was $6.82 for the lowest paid direct- care workers (personal and home care aides in home healthcare) and $8.86 for the highest paid (nursing aides in nursing facilities). Between 20 and 30 percent of longterm care aides worked only part-time. many direct-care workers must rely on public benefits to supplement their income. About 28 percent of aides lived in poverty in 2000 and, among single-parent aides, 20 to 35 percent received food stamps.[11] Nursing-home aides had the third highest injury rate among US workers, but only 30 percent had health insurance.[12] Although the law of supply and demand would suggest that wages should rise to attract new workers, budget squeezes on medicaid (the primary payer for long-term care) hold down reimbursement rates, thereby depressing wages.[13]

Nurse and aide staffing shortages affect quality of care. The federal centers for medicare and medicaid Services found that understaffing "severely affected quality" in 54 percent of nursing facilities in the United States in 2000. This included care that was unsafe for workers and residents, lack of continuity, and denial of care.[14] more than 40 states reported in a 1999 survey of state long-term care ombudsmen that aide shortages were "critical." high turnover—more than 100 percent annually in nursing facilities in some states—exacerbates staff shortages and quality problems.[15]

IMMIGRANTS IN THE DIRECT-CARE WORKFORCE

Immigration has long offset labor shortages in industries such as agriculture, computer programming, and healthcare. today, immigrants account for a significant proportion of workers in a number of healthcare occupations. For example, in 2005 more than a quarter of surgeons and physicians in the United States were foreign-born.[16] According to the 2005 American community Survey (ACS), there were 2.5 million direct-care workers (or "paraprofessionals") age 18 and above in the US labor force, accounting for almost 2 percent of all employed persons. Three quarters of paraprofessionals worked in nursing, psychiatric, and home-health jobs. One in five was born abroad. Nearly nine in ten were women (Figure 2). Foreign-born women had the highest likelihood of being employed in direct-care jobs. more than 5 percent of all foreign-born women in the labor force worked in directcare jobs, compared to 3 percent of native-born women and less than 1 percent of all native-born workers.

Figure 2:

DIRECT-CARE WORKERS AGE 18 AND OLDER, BY NATIVITY & GENDER, 2005

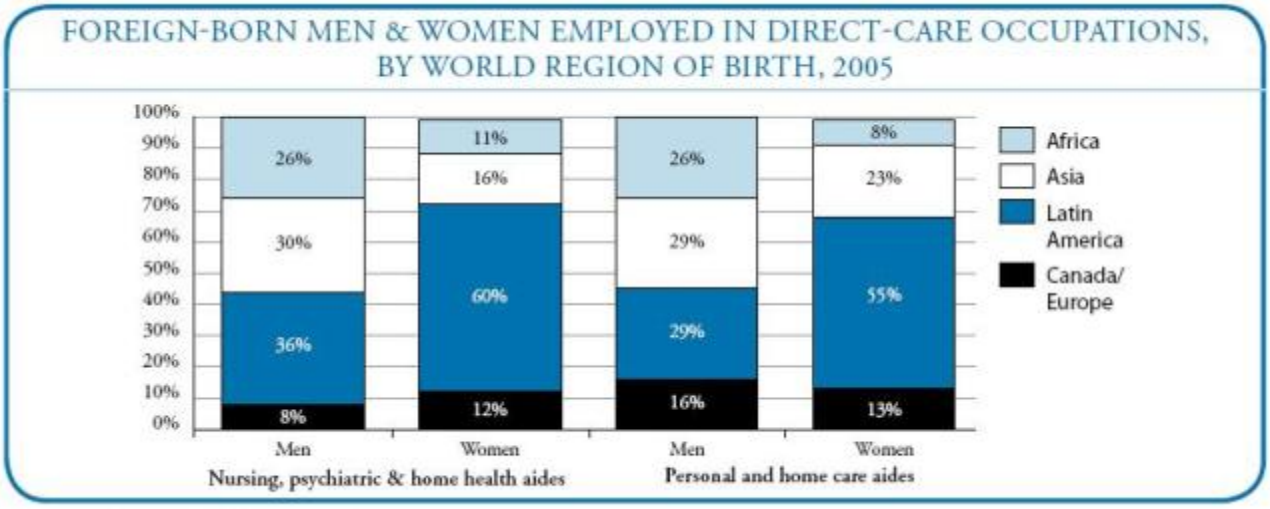
	Total	Nursing, psychiatric & home health aides	Personal & home care aides
Number	*2,465,125*	1,844,727	620,398
Percent foreign-born	*20.8%*	19.6%	24.2%
Percent women	*87.5%*	87.8%	86.6%

Source: 2005 American Community Survey.

Foreign-born direct-care workers tend to be older than their native-born counterparts. About 30 percent of nativeborn workers in direct-care jobs were under 30 years old in 2005, compared to 13 percent of foreign-born workers. conversely, the proportion of foreign-born workers was higher among workers age 30-44 and 45-65. About 44 percent of foreign-born workers in direct-care jobs were between age 45 and 65, compared to 34 percent of natives. Foreign-born women in direct-care jobs, on average, were older than either foreign-born men or native-born men and women.

Healthcare aides, both foreign-born and native-born, are increasingly likely to be people of color. Between 1980 and 2000, the share of whites fell from 36 percent to 14 percent among foreign-born aides and from 75 percent to 63 percent among native-born aides.[17] In 2005, more than 60 percent of foreign-born women employed in nursing and home health aid jobs, and 55 percent of foreign-born women employed as personal and home care aides, were from Latin America. Among foreign-born men, the distribution by region of origin was more equal. However, irrespective of gender, direct-care workers tended to be of non-European origin (Figure 3).

Figure 3:

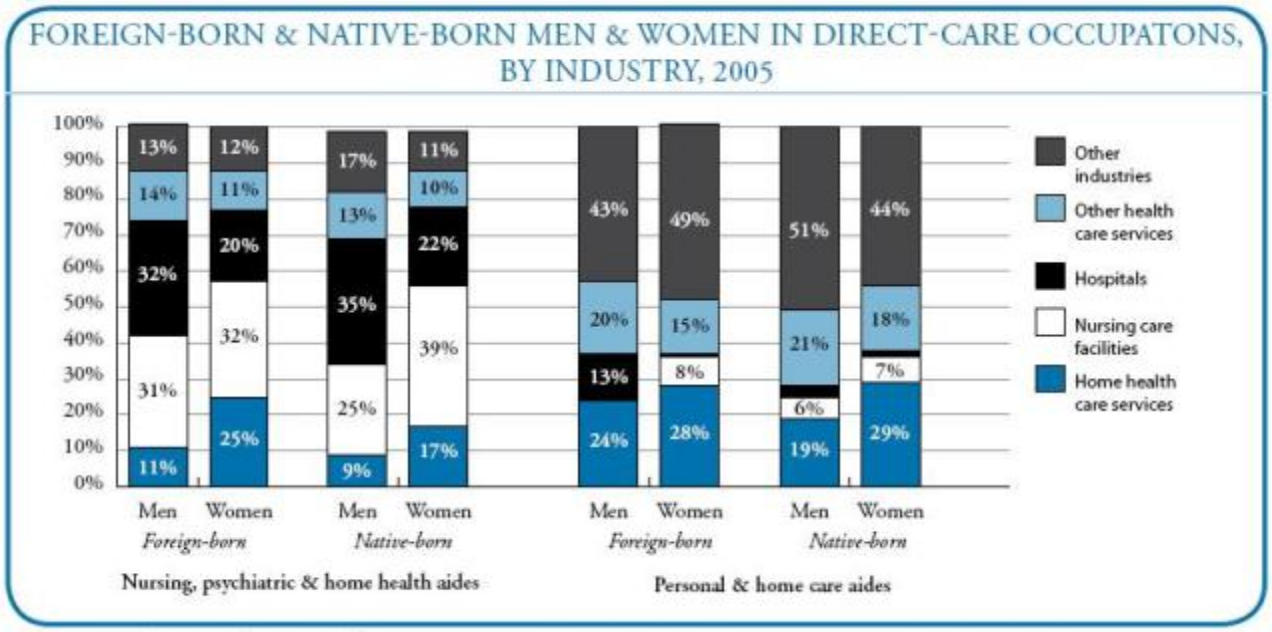


Source: 2005 American Community Survey.

The majority of direct-care workers tend to have low levels of education, although there are significant differences among workers. Nearly two-thirds of personal and home care aides age 25 and higher had a high-school diploma or less education in 2005. Slightly less than 60 percent of nursing and home health aides had no more than a high-school diploma. About 15 percent of foreign-born direct-care workers had a college degree—twice as high as their native-born counterparts, suggesting the underutilization of foreign educational credentials.

Regardless of nativity, men in nursing and home health aid occupations were more likely than women to be employed in hospitals. Women were twice as likely as men to be employed in home healthcare services. Nearly half of personal and home-care aides worked in industries outside of healthcare such as individual and family services and private households (Figure 4), both of which are less regulated and less likely to offer health and pension benefits.

Figure 4:



Source: 2005 American Community Survey.

Given the increasing diversity of care givers and their clients, it is not surprising that "cultural competence" plays an important role in the quality of care. "cultural competence" refers to the ability of healthcare providers to understand their own cultural beliefs and practices as well as those of their clients, and to provide care in a manner that does not impose one's own system of cultural references on others. A 2003 study found that cultural competence greatly influences the ability of nurses and aides to provide care and disease management to diverse patients.[18]

There are substantial differences between cultures with regard to norms and expectations about care giving by family members, the appropriate reactions to pain, illness, and death, and the expression of emotions to outsiders.[19] For example, Asians and hispanics are more likely than other ethnic groups to prefer family-centered decision making around end-of-life issues.[20] Leading-edge training in long-term care requires cultural self-awareness and cultural knowledge of others, including skills in assessing how cultural beliefs and values impact actions and learning to avoid stereotyping.[21] cultural understanding fosters positive outcomes on the job in terms of improved team functioning, lower turnover, and reduced stress.[22]

CURRENT IMMIGRATION POLICIES AGGRAVATE LABOR SHORTAGES

US immigration law provides virtually no opportunities for foreign paraprofessionals to work in the united States on a temporary basis or to come here as permanent immigrants. There are no temporary visas designed for direct- care workers. And it makes little sense for an employer to sponsor a foreign-born paraprofessional for permanent immigration because the waiting period is so long due to the fact that the number of immigrant visas

available for all less-skilled workers is capped at only 5,000 per year.[23]

High-skilled healthcare workers have more opportunities to work in the United States. The H-1A visa category was created for temporary employment of foreign-trained registered nurses (rNs) under the 1989 Immigration Nursing relief Act. Between 1989 and 1995, 6,512 nurses arrived through sponsorship by employers via the H-1A program, but the program expired in 1996. Three years later, the Nursing relief for disadvantaged Areas Act of 1999 established the H-1C visa for foreign nurses to work in understaffed facilities in urban and rural areas that served mostly poor clients. Between 2000 and 2004, the H-1C program allowed 500 nurses to take temporary employment each year. Although the program initially was ended in 2004, congress reauthorized it for another three years effective december 2006. Another avenue available to nurses and other skilled healthcare professionals from abroad is the H-1B program. however, one of the requirements for an H-1B visa is a college degree, which nurses do not need and seldom have as a condition to practice SKILLed nursing.[24]

In 2003, a committee headed by former Senator david durenberger (r-mN) recommended that policymakers consider expanding immigration as one of five ways to meet the future need for paraprofessionals—the other four ways being to encourage younger, older, and male workers, as well as welfare recipients, to enter direct-care occupations. however, the committee noted that, to be successful, these efforts must include the offering of competitive wages, English as a Second Language (ESL) classes, healthcare and retirement benefits, and job training. The committee further suggested that granting employment status to undocumented workers is a promising way to increase the eligible pool of workers. In order to avoid an influx of cheap labor that would result in the deterioration of wages and working conditions, all workers—regardless of nativity—must have the same labor protections, opportunities for career mobility, and training.[25]

EFFECTIVE TRAINING PROGRAMS FOR IMMIGRANT WORKERS IN LONG-TERM CARE

There are relatively few examples of programs that link immigrants to jobs in long-term care. But, of the handful in existence, three in particular stand out. In contrast to these models, the more common avenues for immigrants and non-immigrants alike to find jobs in long-term care is through employers' recruitment of individual workers and word of mouth among workers themselves. These paths are much less likely to offer the special support that upgrades immigrants' professional and language SKILLs, and that helps employers take advantage of the special cultural capital that immigrants bring to long-term care settings.

The International Institute of Minnesota (St. Paul, Minnesota)

The International Institute of minnesota (IIM) is one of a network of non-profit social-service agencies that receives federal and other funding to help refugees and immigrants settle in communities throughout the united States. In 1990, IIM launched a Nursing Assistance Education Program to promote an area of employment in which immigrants

might excel given that many of them care for elderly family members. What they needed was extra support, especially in learning English, to get through training. At the time, Certified Nursing Assistant (CNA) training in minnesota took one week, which was not enough to help with language transition.

To meet the language needs of immigrants, IIM expanded the program to 11 weeks by integrating the state service training curriculum with an ESL program on medical language. IIM hired an ESL teacher and an instructor who was a registered nurse. The program first taught language, then content and SKILLs, and then reviewed language. Although these program features significantly increased the amount of time spent on training and preparation and required outside funding, almost all students passed to become state certified. This approach continued until 1998, by which time many West Africans had settled in the twin cities. Since most West Africans speak English, language *per se* was not the issue; it was accent. So IIM added 6-week and 8-week training programs which offered less ESL support and more focus on content.

As more immigrants completed the program, they began to run into problems with completing job applications, interviewing for jobs, and resolving conflicts in the workplace. IIM developed a series of teaching modules in conjunction with nursing-home human-resources departments to address these issues. Students grew to trust instructors to help with other settlement issues, including housing, child care, and health insurance. This support took pressure off of the students while they were studying.

IIM also conducted workshops with local healthcare institutions, many of which continually sought IIM graduates. Almost all the graduates initially were employed in nursing homes, although a few with exceptional SKILLs and educational backgrounds began in hospitals. In 2004, 139 students from 19 countries were enrolled in the CNA training program: 130 graduated and 129 became statecertified nursing assistants. The 2004 graduates worked in 46 healthcare institutions in the twin cities area. Over the 15-year history of the program, 956 of 1,044 enrolled students graduated, with 98 percent of graduates being certified as nursing assistants. Nearly all of them worked in nursing homes, but about 5 percent worked in hospitals and a few in home healthcare.

Starting salaries in nursing homes in the twin cities are $10.50-$11.00 per hour, with benefits included. About 60 percent of students entering the training course are unemployed when they start, and those who are working usually earn very little in menial jobs. Anecdotal evidence from employers suggests that IIM graduates tend to stay longer in the field than other nursing home workers. Nursing homes value a stable workforce since turnover is traditionally high among aides, requiring constant recruitment and training.

In 1999, IIM recognized that many students wanted to move up in the nursing field, so it started a two-prong medical career Advancement Program (MCAP). A career counselor educated students about career options and helped identify schools which offered the required training. In addition, there were two 10-week sessions to help students get ahead in higher education by teaching computer, math, reading, and listening SKILLs. Financial

help was available as well. MCAP has assisted over 100 aides to become licensed practical nurses, registered nurses, lab technologists, surgical technicians, and phlebotomists. In 2006, 119 MCAP clients were enrolled in college classes for medical-career advancement. upon graduation, trainees have been placed in healthcare positions with wages that are 30-40 percent above their previous income.

It is a struggle to find on-going funding for these programs. The Nursing Assistance Education Program is funded by the greater twin cities united Way, mcknight Foundation, and resettlement Programs Office of the minnesota department of human Services. MCAP is funded by the greater twin cities united Way, St. Paul Foundation, F.r. Bigelow Foundation, Otto Bremer Foundation, minnesota department of Employment and Economic development, and private donors.

Paraprofessional Healthcare Institute (New York City)

The Paraprofessional Healthcare Institute (PHI) is the non-profit affiliate of cooperative home care Associates (CHCA), which operates in manhattan and the Bronx, and care at home (CAH), which operates in Brooklyn. Both CHCA and CAH are cooperatives of home-care workers which PHI supports in recruitment and training efforts. Through its SKILL center, PHI also trains supervisors and peer mentors and assists in the management of home care, assisted living facilities, and nursing homes. Approximately 500 workers per year are trained for placement at both CHCA and CAH. In addition, PHI is involved in advocacy and policy work, runs the National clearinghouse on the direct care Workforce, and operates in New York, Pennsylvania, michigan, and northern New England.

CHCA is PHI's "flagship." After 20 years of operation, CHCA now employs 950 women. According to a study by the Aspen Institute, employees can become co-op owners after three months of satisfactory employment. Then they put down $50 of the required $1,000 share, the balance of which can be paid with small deductions from their paychecks ($3.65 in 2002). Full shares pay annual dividends of $200-$400.[26] more than half of the board of CHCA is elected by workers. Although CHCA is not an immigrant organization, 54 percent of its workers are immigrants. About 45 percent of the immigrants in CHCA are from the dominican republic, elsewhere in the caribbean, or central American countries. Prior to training, which is conducted in Spanish and English, 41 percent of enrollees were unemployed for more than 3 years, 36 percent were receiving public assistance, 45 percent were receiving food stamps, 73 percent were on medicaid, 37 percent lacked a high-school diploma or equivalent, and 32 percent were single heads of households with children younger than 13. PHI recruits primarily by word of mouth, as well as through referrals from community-based organizations. The training takes 4-5 weeks, which is twice as long as the home-care training requirement in New york. PHI staff offer support for trainees in dealing with issues such as housing, childcare, and taxes.

The SKILL Center utilizes an employer-based approach. All trainees become employees of CHCA or CAH, both of which contract with agencies and payers (primarily medicaid)

to provide home care. Workers trained by the SKILL center earn wages that are two dollars above the industry average. The starting industry wage is $7.25 per hour, and the average (including weekends, overtime, and differentials for "difficult-to-serve clients") is $9.26. With benefits, PHI estimates that the value of the total package is $11.64 per hour. Both CHCA and CAH are organized by Service Employees International union (SEIU) 1199. About 40 percent of administrative jobs in CHCA are held by former aides. CHCA is a preferred provider of aides for the New York Visiting Nurse Service, which serves the South Bronx and Harlem.

PHI and CHCA recently founded the Independence care System, which is a managed-care organization serving persons with disabilities at home. It operates under prepaid, "capitated" funding from medicaid (i.e., set payments per client per month from which the cost of services and administration are paid). It serves individuals with significant disabilities, primarily working-age adults. The 800 members of Independence care average 1.4 full-time equivalent personal care attendants apiece, which translates into many new jobs for aides. This is an area of future growth for both CHCA and CAH.

1199 SEIU Employment and Training Center (New York City)

1199 SEIU represents more than 70,000 housekeepers, home attendants, and home health aides employed by 70 participating agencies in New York city. With funds from the state, employers, grants, and the union itself, SEIU trains workers at all levels. Like PHI, the majority of SEIU recruits and workers are immigrants (56 percent in 2003) and the union tailors training to help immigrants overcome barriers to job entry and advancement. The training center aims to build a workforce that is both culturally and linguistically competent. An example is a recent program to train chinese-speaking home-care workers to become CNAs in institutional settings. moving from home care to institutional care increases the pay of aides from $8-$9 per hour to $12-$13.

1199 SEIU created a pilot training program at the request of Brooklyn's Lutheran medical center and its af- filiate nursing home, Augustana Lutheran center, which had growing numbers of chinese, russian, hispanic, and Arab patients. The medical center wanted to fill vacancies for aides who were bilingual in chinese and English. The SEIU program included ESL, English immersion, collaboration with management, and CNA instruction—and recruited experienced chinese-speaking home-care workers to enroll. The time for the training was 240 hours, versus the 120 hours that are standard for CNAs, plus two weeks of ESL up front. The program also dealt with the problems home-care workers face in transitioning from a worker/patient ratio of 1:1 to 1:15. The training was fi- nanced by a government grant and by the SEIU Education and training Fund. Eleven of the 14 chinese home-care workers who initially enrolled in the program completed the training, passed the New York state CNA SKILLs exam, and are currently employed. In addition to better wages, the move from home care to institutional jobs is attractive because it is less likely to involve part-time work and frequent scheduling changes.

The experience gained from this pilot program is now being applied in a replication program supported by the 1199 SEIU homecare Industry Bill michelson Education Fund.

Letters and flyers have been sent to employers to solicit jobs and training support. The recruitment letter says the program "will help your institution access a pool of qualified, caring entry-level workers who are experienced and culturally diverse." The flyer emphasizes the motivation of immigrants to succeed and points out that many have nursing and medical training from their home countries. homecare workers attending ESL and pre-licensed practical nursing classes will be recruited, as well as 1199 SEIU home-care members throughout the five boroughs who meet the language requirements of employers. training has been expanded to include russian, Spanish, and creole speakers.

Incumbent workers who are enrolled full time will receive a stipend and continued health benefits. Participating employers are required to complete a needs assessment; provide commitments to hire participants who successfully complete the program; provide release time (i.e., allow workers to be away from their regular shifts without penalty), stipends, and benefits for workers during training; and work with fund staff in conducting on-site training and follow-up. One of the stated goals of the initiative, as put forth in the letter to employers, is to "facilitate the entry of greater numbers of people of color and immigrants into new opportunities for upward mobility by preparing them for entry into a nursing career ladder…"

FUTURE RESEARCH AND POLICY REFORM

The need for long-term care in the United States will increase in the years to come as the population—particularly the native-born population—grows older. As a result, immigrants will continue to play a significant role in the growth of the US labor force in general and of the direct-care workforce in particular. high turnover rates and widespread vacancies for paraprofessional positions indicate that there are not enough native-born workers to meet labor demand. The problem in attracting enough native-born workers is not high barriers to entry. In Minneapolis, for example, training for certification takes only a one-semester, four-credit course at a community college. The cost is $575, financial aid is available, and jobs are plentiful. rather, the problem is relatively low wages and difficult work—just the type of jobs that immigrants (often recent arrivals) are ready to take. If immigrants are pulled into this work without training and support beyond the industry minimum, they could become a part of—or even deepen—the cycle of low wages, high turnover, and compromised quality of care that plague the direct-care industry today.

However, training programs that are sensitive to the needs of immigrant workers can produce and place workers who are SKILLed, loyal, and highly valued by employers. good training programs are designed to work closely with employers to ensure placement, retention, and opportunities for advancement for workers, including chances for aides to advance to nursing and other fields. A successful training program will assist immigrant workers in learning English, preparing for higher education, finding housing and child care, and navigating the immigration system. Labor unions and worker cooperatives can play a valuable role in setting the standard for decent wages and benefits for all workers, both immigrants and native-born.

One important commonality among the three training programs analyzed in this report is that there was third-party support to cover the costs of training and even stipends for workers. Funding came from unions, state governments, the united Way, and other sources. Little funding came from the immigrants and other low-income workers who underwent training, or the nursing homes and home-care agencies that employed the workers. In general, both employers and workers in the industry operate too close to the economic margin to support this type of tailored training and support.

Research is needed to identify other models for recruitment, training, and placement of immigrant workers in long-term care jobs. The three models above are not the only possible approaches. researchers should examine the costs and benefits of other types of long-term care training programs in a more detailed and systematic manner. What are the essential elements of training and support? What kinds of ties to employers foster satisfactory placements and retention? how do costs compare to standard training, and how can costs be covered? how do training programs help workers obtain more advanced training and certifications? What role can government agencies play in training? do the immigrant workers who participate in a particular kind of program do better in terms of retention, employer satisfaction, SKILLs, and wages than immigrant workers who do not participate? given the growing demand for immigrants to fill direct-care jobs, it is in the best interests of long-term care clients, providers, and workers if governments and private donors foster high-quality training and placement programs rather than leaving the future of the direct-care industry to chance.

Endnotes

[1]U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2004, April 6, 2007, Table 1.1: Population by Age, Sex, Race and Hispanic Origin, 2004.

[2] Wan He, et al., 65+ in the United States: 2005 (Current Population Reports, P23-209). Washington, DC: U.S. Census Bureau, December 2005, p. 6, 169.

[3] Health Resources and Services Administration, U.S. Department of Health and Human Services, Nursing Aides, Home Health Aides, and Related Health Care Occupations--National and Local Workforce Shortages and Associated Data Needs, February 2004, p. vi-vii.

[4] Wan He, et al., 65+ in the United States: 2005, p. 9-13.

[5] ibid., p. 6, 162.

[6] ibid., p. 169.

[7] Judith Treas, "Older Americans in the 1990s and Beyond," Population Bulletin 50 (2), May 1995: 1-48.

[8] Daniel E. Hecker, "Occupational Employment Projections to 2014," Monthly Labor Review 128(11), November 2005, Table 3, p. 70-72, 77.

[9] U.S. Department of Labor & U.S. Department of Health and Human Services, The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation: Report to Congress, May 14, 2003, p. 3, 15-16. [10] Grantmakers In Health, Long-Term Care Quality: Facing the Challenges of an Aging Population (Issue Brief No. 6). Washington, DC: April 2001, p. 8.

[11] Health Resources and Services Administration, Nursing Aides, Home Health Aides, and Related Health Care Occupations, February 2004, p. 9-10.

[12] Grantmakers In Health, Long-Term Care Quality, April 2001, p. 10.

[13] Steven L. Dawson & Rick Surpin, Direct Care Health Workers: The Unnecessary Crisis in Long Term Care. Washington, DC: Aspen Institute, January 2001, p. 15.

[14] Health Resources and Services Administration, Nursing Aides, Home Health Aides, and Related Health Care Occupations, February 2004, p. 15.

[15] U.S. General Accounting Office, Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern (GAO-01-750T), May 17, 2001, p. 8, 11.

[16] Esha Clearfield & Jeanne Batalova, "Foreign-Born Health-Care Workers in the United States," Migration Information Source (http://www.migrationinformation.org). Washington, DC: Migration Policy Institute, February 2007.

[17] Donald L. Redfoot & Ari N. Houser, "We Shall Travel On": Quality of Care, Economic Development, and the International Migration of Long-Term Care Workers. Washington DC: AARP Public Policy Institute, October 2005, p. 65-70.

[18] Denise Tyler, An Argument for Cultural Competence Training for Staff in Diverse Long-Term Care Facilities. Waltham, MA: Brandeis University, 2003.

[19] Kathleen Huttlinger, "At Home with Diversity," Home Care Provider 1(1), January-February 1996: 20-24.

[20] Jung Kwak & William E. Haley, "Current Research Findings on End-of-Life Decision Making Among Racially or Ethnically Diverse Groups," The Gerontologist 45(5), October 2005: 634-641.

[21] R. Clermont, J. Samter & A. Fisher, "A Celebration of Cultures in a Long-Term Care Facility," Geriatric Nursing 14(5), September-October 1993: 273-276; Y. Shaw-Taylor & B. Benesch, "Workforce Diversity and Cultural Competence in Healthcare," Journal of Cultural Diversity 5(4), Winter 1998: 138-146; C. Ellis & J.A. Sonnenfeld, "Diverse Approaches to Managing Diversity," Human Resource Management 33(1), 1994: 79-109.

[22] J.C. Walton & M. Waszkiewicz, "Managing Unlicensed Assistive Personnel: Tips for Improving Quality Outcomes," MEDSURG Nursing 6(1), 1997: 24-28; M.S. Waite, J.O. Harker & L.I. Messerman, "Interdisciplinary Team Training and Diversity: Problems, Concepts, and Strategies," Gerontology and Geriatrics Education 15(1), 1994: 65-82; K.L Ulrey & P. Amason, "Intercultural Communication Between Patients and Health Care Providers: An Exploration of Intercultural Communication Effectiveness, Cultural Sensitivity, Stress, and Anxiety," Health Communication 13(4), 2001: 449-463.

[23] A total of 10,000 employment-based green cards are allotted for less-SKILLed workers each year, but half of these are reserved for beneficiaries of the 1997 Nicaraguan Adjustment and Central American Relief Act.

[24] Rob Paral, Health Worker Shortages and the Potential of Immigration Policy. Washington, DC: Immigration Policy Center, American Immigration Law Foundation, February 2004, p. 9.

[25] Steven L. Dawson, Long-Term Care Financing and the Long-Term Care Workforce Crisis: Causes and Solutions. Washington, DC: Citizens for Long Term Care, January 2003, p. 28-29.

[26] Anne Inserra, Maureen Conway & John Rodat, Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach. Washington, DC: Aspen Institute, February 2002, p. 25.

About The Author

Walter Leutz is an Associate Professor at the Heller School for Social Policy and Management at Brandeis University in Waltham, Massachusetts.