Editorial

Migrant Carers—Saving or Sinking the Sustainability of Eldercare?

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The provision of adequate, accessible and affordable care and support is a major issue for the ageing societies of Europe and the North America. Demographic ageing has not only increased the proportion and number of older adults requiring care, but has also reduced the number of younger adults entering the health and social care sectors. In particular, research shows that most older people wish to remain living independently (Leeson et al. 2003). As the OECD International Migration Outlook 2010, reports throughout the OECD one likely source of workers in these occupations is the immigrant care workforce.

This edited collection is part of a two-part special edition on Migration and Ageing. This first part reflects a collaboration between the Migration and Ageing Populations Centre (MAP)¹ and the Centre for Migration, Policy and Society (COMPAS)² both based at the University of Oxford. It considers the provision of care for older people by migrant eldercare workers in the United Kingdom, the Republic of Ireland, Canada and the United States and draws on research funded by the Nuffield Foundation and Atlantic Philanthropies. The second volume: Eastern Europe—Migration and Ageing, will appear as Volume 4 in 2011 and will reflect research undertaken by the MILES³ collaborative research network.

¹MAP Migration and Ageing Populations Centre addresses the interaction of migration, fertility and mortality (<http://www.ageing.ox.ac.uk/research/global/demography>). It has particular expertise on migrant health care workers and the impact of these movements on both informal family carers and the formal care sector. Research is undertaken in Africa, Asia, Latin America and Eastern Europe. MAP members are contributing to the UK *Global Migration and Environment* Foresight Review.

²COMPAS Centre for Migration, Policy and Society aims to provide a strategic, integrated approach to understanding contemporary and future migration dynamics across sending areas and receiving contexts in the UK and EU.

³MILES is a European collaborative research network—originally funded by NORFACE and hosted by the Oxford Institute of Ageing—which investigates the growing importance of legal and illegal migrant care workers in the informal and formal care industries in Europe, in the context of population ageing and a varying societal care mix determined by different cultural and historical-political traditions.

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These two special volumes represent a new multi-disciplinary collaboration whereby demographers interested in population ageing and migration as one response to this demographic trend, have worked closely with colleagues from migration studies who have realised the necessity of understanding population ageing as a context to their work.

Population ageing has resulted in a tightening of the economic sustainability of many public pension and healthcare systems. As OECD (2010) highlights “After raising the participation rate of the resident population, one way to reduce the need for higher taxes and pressure on public finances is to bring in immigrant workers, who contribute to pension and health-care regimes, but do not draw on them immediately. Ensuring that both settled immigrants and newcomers to OECD countries from varied cultural and social backgrounds play a productive role requires good policies to ensure good outcomes”. These two angles are addressed in the collaborations between MAP and COMPAS (current volume) and MAP and MILES (Volume 4, forthcoming).

As the report “Ageing Horizons: Migration and Ageing 2010” explores, international migration is already a strong contributor to population growth in many countries. On average for OECD countries, 59% of population growth over the period was accounted for by migration and up to 90% of population growth in southern Europe, Austria and the Czech Republic. Although migration has declined in most OECD countries as a result of the economic crisis between 2009–2010, this followed 5 years of averaging 11% growth.

Migration within free movement areas accounted for about a quarter of all migration in the OECD in 2008, and 44% in Europe, and for more than half of all migration in Norway, Switzerland, Austria and Denmark. Up to one third of permanent immigrants in the UK and Iberian Peninsula arrived for work-related reasons, while family migration is preeminent in the United States (65%), France and Sweden (OECD 2010). In terms of occupational strata, the social and health care services have increased in many OECD countries. In the US health care sector there was a 5% increase, and a 3% increase in Europe, with immigrants taking a sizeable percentage of these new jobs.

So-called replacement migration has been regarded in some quarters as a viable means of compensating for population ageing. However, recent research has shown in several countries that the levels of replacement migration that would be needed for this purpose would be unrealistically high (United Nations 2000; Leeson 2004). Even so, selective migration into pre-designated sectors of the labour force is sometimes seen as a possible avenue of addressing the needs of an ageing population—for example in respect of the provision of care and support for older people.

The provision of care and support for older people depends on labour market and welfare regimes dominant in the country in question, and the two key sources of difference across countries are the private-public mix of provision and the differentiation between health and social provision. The increasing demand for and costs of this provision have seen changes in the frameworks of provision but the traditional typologies still serve as a relevant platform of categorisation. The obvious starting point is Esping-Andersen’s *Three Worlds of Welfare Capitalism* (Esping-Andersen 1990), since when both a Southern European (Ferrera 1996, for example) and a Central Eastern/Eastern European (Standing 1996; Manning 2004) regime

have been added. In addition, this original welfare state typology has been criticized for focusing on the labour market, thereby ignoring important (in terms of care and support for older people especially) gender and family issues (Lewis 1992; Daly 2000). These issues led to the development of the welfare regime model to incorporate the ideas mentioned above of de-familialisation (Esping-Andersen 1999; Harper 2004) but also those of generational conflict (Esping-Andersen 2002; Leeson 2005).

However, developments over the last half of the 20th century and the expected developments in the first decades of the 21st century with regard to for example future generations of older people and their expectations, would indicate that this welfare regime categorisation is far from static.

Given existing differences in the care and welfare cultures developed in individual countries, the use of migrant labour in the eldercare sector is in some instances predominantly in the formal and in other instances in the informal sector. Germany and the UK, for instance, combine a longstanding tradition of institutionalised care for older people with an equally longstanding experience of migrant labour in the health and eldercare sectors. However, while Greece, Italy, Spain and Portugal, for instance, have almost no tradition of employing migrant labour in the formal health care sector, these countries are witnessing unpaid family care being replaced/supplemented by in-house migrant labour.

The distinction between the employment of migrant labour in either the formal or the informal eldercare sector is linked strongly to issues of quality of care and the financing of care. A regime with a predominantly public provision of care and support tends to strengthen the formal (health-based) component of care and support for older people, while a regime with privately financed provision encourages cheap, informal alternatives to family care.

The UK is seen as having a welfare regime determined by a strong public component, but the UK does also reflect the Southern European regime with a strong familial component of provision (Bettio and Plantenga 2004). Furthermore, the UK has a longstanding tradition for the institutionalised care of older people and the employment of migrant labour in this field. There is no such tradition in Southern Europe, which on the other hand is experiencing a dramatic substitution of family care by predominantly female migrants (Bettio et al. 2004b).

Recent comparative analysis of the provision of eldercare in Denmark, Italy and Greece indicate that at current prices and with current supply conditions there are no obvious advantages inherent in the system of any of these countries in terms of cost-effectiveness or quality of care (Bettio and Plantenga 2004). However, the Italian and Greek systems of provision have the (economic) advantage of placing most of the financial burden on families rather than on public budgets. This is the case even though cash transfers to families with eldercare responsibilities may be substantial. One drawback in the Italian and Greek cases, however, is that in response families with eldercare responsibilities will attempt to limit their costs by minimizing wages per hour rather than adopting medical and paramedical technology to reduce time spent caring. This is a natural choice in as much as such technology entails high investment costs and is not viable on a small (family) scale.

For demographic and economic reasons, the supply of migrant labour to replace/supplement informal or family-based eldercare provision is unlikely to be

sustainable in the long-term. In addition, the fiscal viability of the Greek and Italian provision must be considered in relation to the issue of equity—it depends on exploitative labour market conditions for migrants and a drain on the care resources in the migrants' countries of origin.

In addition to the discourse relating to welfare regimes outlined above, one can also distinguish between different care regimes in Europe in accordance with Anttonen and Sipilä (1996), who found it legitimate to speak of social care regimes, distinguishing two distinct models of social care services—a Scandinavian model of public services and a Southern European family care model—into which European countries can be clustered.

The first cluster comprises countries that appear to delegate all aspects of the management of care to the family, for example Italy, Greece and Spain. These countries score high on the index of informal care, whereas formal care arrangements for children and/or older people are less developed. The families in these cases operate as *social clearing houses*, with intense and diverse exchanges within the family network. This is consistent with the fact that in these cases, social transfers have been more frequently granted to older people, in the form of pensions, and given priority consistently over the provisions of services (Ferrera 1996). Atypical cases within this cluster are Portugal and Ireland. Portugal does share the relevant features with regard to formal care arrangements (except for the index of financial provisions), but has a surprisingly low score on the informal care indicator. Ireland seems to be atypical because of its medium score on services provided for older people and could therefore be interpreted almost as a stepping-stone, with care provision falling between the services provided by countries in the first cluster and those provided by the United Kingdom and the Netherlands, for example, in the second cluster.

In the UK and the Netherlands, informal care is again important. The specific element of this care regime, however, is the major difference in the policy approach towards children and that towards older people. Whereas care for children is to a large extent privatized, there is a much larger collective provision of services for older people. In the Netherlands, the family is regarded as the *natural* provider for children, while the state is seen as the steward for older people. This is partially true in the UK in respect of older people.

The third cluster includes Austria and Germany, for example, where countries are characterized by a largely private or informal care strategy. However, the costs of this strategy—in terms of forgone income—are partly compensated by collective arrangements. Countries score in the medium range on the leave and financial provisions indicator, while they are medium providers with regard to institutional care for older people.

The fourth and final cluster comprises the Nordic countries, which provide moderate to high levels of formal care resources. An important characteristic of this care model is its universalist approach. There is a broad range of public care services, covering a large segment of the population (Sainsbury 1996). The family plays only a modest role as a care provider, with the state replacing rather than supporting the family.

The comparison between the Scandinavian and the Southern European models seems to indicate that there are *high road* and *low road* approaches to meeting the

challenges of ageing populations to the eldercare sector. The *high road* approach implies universal coverage, uniform basic standards of care, higher reliance on technology, and professional labour markets for carers. The *low road* approach saves on public expenditure by utilising the principle of subsidiarity without guaranteeing common (basic) standards of care or of working conditions and failing to encourage professional labour markets for carers. This relates to the difference between *formal* and *informal* care, where formal care is regulated by formal contractual arrangements and within defined professions, while informal care is family care, care by volunteers and contractually unregulated care work.

The *high/low road* dichotomy need be neither predetermined nor static but depends rather on the scope, composition and process of integration of migrant labour in the eldercare sector. As the above comparisons exemplify, alternative approaches to the provision of eldercare should be assessed in terms of long-term sustainability and equity as well as cost-effectiveness and quality.

The sustainability of the provision of eldercare depends intrinsically on *variously sourced eldercare* (family care, independent care and state care on the one hand and externally sourced care or migrant care on the other hand) regardless of the type of care regime in question. Regimes with a combination of family and state care find this increasingly unsustainable because of the costs involved (OECD 2003), while regimes with family care orientation find this increasingly unsustainable as family structures and values change (Harper 2004). In both instances, the potential for migrant (female) carers (in both the formal and informal sectors) is present.

The utilisation of externally sourced care is a response to increasing eldercare needs and labour shortages in destination countries fuelled by the progressive ageing of their populations (Buchan 2002; Buchan and Sochalski 2004). Thus, on the one hand, an intense debate has arisen on the movement of formal eldercare workers (Buchan and Sochalski 2004), and while their migration serves to alleviate eldercare shortfalls in the host countries (Smith and Mackintosh 2007), their loss in their countries of origin may damage eldercare provision there (Eastwood et al. 2005; Stilwell et al. 2004; Mensah et al. 2005). On the other hand, and parallel to this, there is an equal concern about the movement of informal (mainly female) eldercare workers in respect of the implications for the quality and sustainability of eldercare, the relative role and responsibility of family and state in financially providing this eldercare, the work conditions of these carers (Da Roit 2004; Bettio et al. 2003, 2004a, b), and (increasingly) the family context and family impacts in the countries of origin (Harper et al. 2007).

As this volume on the UK, US, Ireland and Canada, and the sister volume on Eastern Europe, demonstrates, the role of migrant health care workers is set to remain a key factor in sustainability of eldercare regimes.

References

- Ageing Horizons. (2010). *Migration and ageing*. Oxford: OIA.
- Anttonen, A., & Sipilä, J. (1996). European social care services: is it possible to identify models? *Journal of European Social Policy*, 6(2), 87–100.
- Bettio, F., & Plantenga, J. (2004). Comparing care regimes in Europe. *Feminist Economics*, 10(1), 85–113.

- Bettio, F., D'Amato, M., & Mazzotta, F. (2003). *Long-term care for the elderly in Italy: is extended family still important?* Mimeo.
- Bettio, F., Mazzotta, F., & Solinas, G. (2004a). *Long-term care in Italy, survey results: gender analysis and long-term care of the elderly*. Rome: European Commission and Fondazione G. Brodolini.
- Bettio, F., Simonazzi, A., & Villa, P. (2004b). The care drain in the Mediterranean: notes on the Italian experience, 25th Conference of the International Working Party on Labour Market Segmentation, Brisbane, July.
- Buchan, J. (2002). Global nursing shortages. *British Medical Journal*, 324, 651–652.
- Buchan, J., & Sochalski, J. (2004). The migration of nurses: trends and policies. *Bulletin of World Health Organization*, 82, 587–594.
- Da Roit, B. (2004). *Changing Intergenerational solidarities in a Mediterranean welfare state*, ISA Sociology of Ageing, Inter-Congress Conference, Roehampton, UK, September.
- Daly, M. (2000). *The gender division of welfare*. Cambridge: Cambridge University Press.
- Eastwood, J. B., et al. (2005). Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK. *Lancet*, 365, 1893–1900.
- Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Cambridge: Polity Press.
- Esping-Andersen, G. (1999). *Social foundations of postindustrial economics*. Oxford: Oxford University Press.
- Esping-Andersen, G. (2002). *Why we need a new welfare state*. Oxford: Oxford University Press.
- Ferrera, M. (1996). The “southern” model of welfare in social Europe. *Journal of European Social Policy*, 6(1), 17–36.
- Harper, S. (2004). *Families in ageing societies—a multidisciplinary approach*. Oxford: Oxford University Press.
- Harper, S., Aboderin, I., & Ruchieva, I. (2007). Impact of female-led health and social care migration on families in source countries. in press.
- Leeson, G. W. (2004). Replacement migration: coping with population change in the Nordic countries, Working Paper, Nordic Centre for Spatial Development, Stockholm.
- Leeson, G. W. (2005). *The Danish longitudinal future study 1987–2002, social and familial networks*. Copenhagen: DaneAge.
- Leeson, G. W., Harper, S., & Levin, S. (2003). *Independent living in later life: literature review*. London: Department for Work and Pensions.
- Lewis, J. (1992). Gender and the development of welfare regimes. *Journal of European Social Policy*, 2(3), 159–173.
- Manning, N. (2004). Diversity and change in pre-accession Central and Eastern Europe since 1989. *Journal of European Social Policy*, 14(3), 211–232.
- Mensah, K., et al. (2005). *The skills drain of health professionals from the developing world: a framework for policy formation*. London: Medact.
- OECD. (2003). Spending on long-term care: projections to 2050. Revisited SG/ADHOC/HEA (2003)3.
- OECD. (2010). International migration outlook.
- Sainsbury, D. (1996). *Gender, equality and welfare states*. CUP.
- Smith, P., & Mackintosh, M. (2007). Profession, market and class: nurse migration and the remaking of division and disadvantage. *Journal of Clinical Nursing*, 16(12), 2213–2220.
- Standing, G. (1996). Social protection in Central and Eastern Europe: a tale of slipping anchors and torn safety nets. In G. Esping-Andersen (Ed.), *Welfare states in transition*. London: Sage.
- Stilwell, B., et al. (2004). Migration of health-care workers from developing countries: strategic approaches to its management. *Bulletin of World Health Organization*, 82, 595–600.
- United Nations. (2000). *Replacement migration: is it a solution to declining and ageing populations?* New York: Population Division.