

Globalization, Women's Migration, and the Long-Term-Care Workforce

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With the aging of the world's population comes the rising need for qualified direct long-term-care (DLTC) workers (i.e., those who provide personal care to frail and disabled older adults). Developed nations are increasingly turning to immigrant women to fill these needs. In this article, we examine the impact of three global trends—population aging, globalization, and women's migration—on the supply and demand for DLTC workers in the United States. Following an overview of these trends, we identify three areas with embedded social justice issues that are shaping the DLTC workforce in the United States, with a specific focus on immigrant workers in these settings. These include world poverty and economic inequalities, the feminization and colorization of labor (especially in long-term care), and empowerment and women's rights. We conclude with a discussion of the contradictory effects that both population aging and globalization have on immigrant women, source countries, and the long-term-care workforce in the United States. We raise a number of policy, practice, and research implications and questions. For policy makers and long-term-care administrators in receiver nations such as the United States, the meeting of DLTC worker needs with immigrants may result in greater access to needed employees but also in the continued devaluation of eldercare as a profession. Source (supply) nations must balance the real and potential economic benefits of remittances from women who migrate for labor with the negative consequences of disrupting family care traditions and draining the long-term-care workforce of those countries.

Key Words: *Aging, Elder custodial care, Filipino Americans, Geriatrics, Globalization, Health services*

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Three trends—population aging, globalization, and women's migration—are gaining momentum concomitantly. Population aging and globalization are heralded with both enthusiasm and caution. Population aging represents progress in public health and medicine, but growing pension and health care costs are challenging nations. Globalization, a key theme of contemporary international political economy, promises improved efficiency in the distribution of resources and higher standards of living for some; but for others—especially in developing nations—it means increasing inequality and poverty (Stiglitz, 2006). One feature of the economic impact of globalization is a third trend—the increase in the transnational migration of women seeking work.

These trends have far-reaching implications for the care of aged adults. Long-term-care settings require a range of workers, and those who provide direct personal care to dependent elders are at the low end of the wage scale. In the United States, the long-term-care workforce is heavily dependent on women from racial/ethnic and minority backgrounds, and increasingly on immigrant women, to fill low-paying, direct-care positions (Montgomery, Holley, Deichert, & Kosloski, 2005; Redfoot & Houser, 2005). In this article, we examine the impact globalization and population aging have on immigrant women in the direct long-term-care (DLTC) workforce. Increasing numbers of older adults, especially those older than 85, are in need of these workers, who are critical to their well-being and in short supply (Paraprofessional Healthcare Institute [PHI], 2005). We suggest that ignoring these international trends may lead to lack of preparedness for meeting the escalating needs for these workers.

We begin with a brief profile of the long-term-care workforce in the United States and explore the impact of population aging, globalization, and women's migration on supply and demand for DLTC workers. We extend the discussion by draw-

ing from the writings of a number of gerontology, globalization, and immigration scholars who have grounded their work within a feminist and gender analysis. We raise questions in three areas—world poverty and economic inequalities, the feminization and colorization of labor, and empowerment and women's rights—with embedded social justice issues that expose the contradictory effects of these global trends on women. Figure 1 presents a framework that identifies issues among the three social justice issues, international trends, and the DLTC workforce in the United States. Finally, we raise practice, policy and research questions around reliance on compensatory migration to meet DLTC workforce needs. We define *international migrants* as persons born in a country other than that in which they reside. Our discussion on migrants focuses on legal labor migration; unless otherwise stated, this excludes refugee movements and human trafficking.

The DLTC Workforce

With the aging of the world's population comes the rising need for DLTC workers. These include nurse aides, nursing assistants, personal care attendants, home care workers, and other paraprofessional workers who provide hands-on care to consumers in hospitals, nursing homes, community-based services, and private homes. A recent study found that about 90% of these workers in the United States were middle aged and female, more than half were non-White, and about 20% were foreign born (Montgomery et al., 2005). Researchers have documented similar gender and age profiles in other developed countries (Korszyk, 2004); others have found an increasing reliance on immigrants to provide this care (Polverini & Lamura, 2004).

The United States, as with other developed countries, has a critical shortage of workers in long-term care, especially DLTC workers (PHI, 2005; Stone & Wiener, 2001). There is no national data set on these shortages; instead, data on shortages are extrapolated from studies from individual states and professional associations (PHI, 2005), projections on job growth compared with demographic changes (Bureau of Labor Statistics, 2003), and what is known about vacancies and job turnover (Better Jobs, Better Care, 2006a; U.S. General Accounting Office, 2001). DLTC work is one of the fastest growing service occupations in the United States; the demand is expected to increase by 63.5%, or about 900,000 new jobs, between 2005 and 2010. To ease this labor shortage, program administrators are turning to immigrant women as potential employees in long-term care (Hagan, 2004; Lowell & Gerova, 2004; Redfoot & Houser, 2005). In fact, the percentage of foreign-born nurses aides in long-term-care settings increased from 6% in 1980 to 16% in 2003 (Redfoot & Houser, 2005).

DLTC workers are the lowest paid workers in long-term care (Bureau of Labor Statistics, 2003; National Clearinghouse on the Direct Care Workforce, 2006). Many work part time, and the median hourly wage for DLTC workers in 2005 was significantly lower than that of the average U.S. worker, \$9.56 compared to \$14.15 (National Clearinghouse on the Direct Care Workforce, 2006). As a result of low wages and part-time work, 19% of home care aides and 16% of nurse aides are poor by the U.S. Census definition (Montgomery et al., 2005). Few jobs offer health insurance or other benefits, or chances for advancement. As a result, there is high turnover, ranging from 40% to 100% (U.S. General Accounting Office, 2001). This increases the motivation to fast-track people, including immigrants, into this field and decreases opportunities to develop a stable, high-quality long-term-care workforce (U.S. Department of Health and Human Services [DHHS] and U.S. Department of Labor, 2003). The passage of the Nursing Relief for Disadvantaged Areas Act of 1999 aimed to address the shortage of trained nurses in specific locales by easing immigration restrictions (Hoppe, 2005), but no similar legislation has been aimed at the recruitment of the DLTC worker. Instead, those who hope to migrate to the United States to work in DLTC must first abide by the stringent U.S. immigration laws. Temporary work visas offer a partial solution but may deny the visa holder the ability to become a citizen (Novelli, 2005).

Three Global Trends Impacting Long-Term Care

Population Aging

We turn now to the first of three international trends that shape long-term care and the DLTC workforce issue—global population aging. In 2006, nearly 500 million people around the world were aged 65 years or older. Projections estimate that by 2030 the number will reach 1 billion, or 1 in every 8 persons (U.S. Department of State and U.S. DHHS, 2007). By 2050, the number of people aged 85 and older—those most at risk for needing long-term care—will increase by 350% (Kinsella & Phillips, 2005; Wiener & Tilly, 2002). Europe has felt the impact of an aging population sooner than other parts of the world, in part due to its high economic standing and generous social policies (Kinsella & Phillips, 2005). Japan will experience the most striking increase: By 2030, 24% of all older Japanese citizens will be aged 85 years or older (U.S. Department of State and U.S. DHHS, 2007). In the United States, the number of older adults is projected to increase by 135% between 2000 and 2050 (Wiener & Tilly, 2002). By 2050, a new demographic shift will occur, when 80% of the world's projected 1.5 billion people older than age 65 will reside in the world's developing regions (Kinsella & Phillips, 2005).

Global aging is gender imbalanced. Women out-

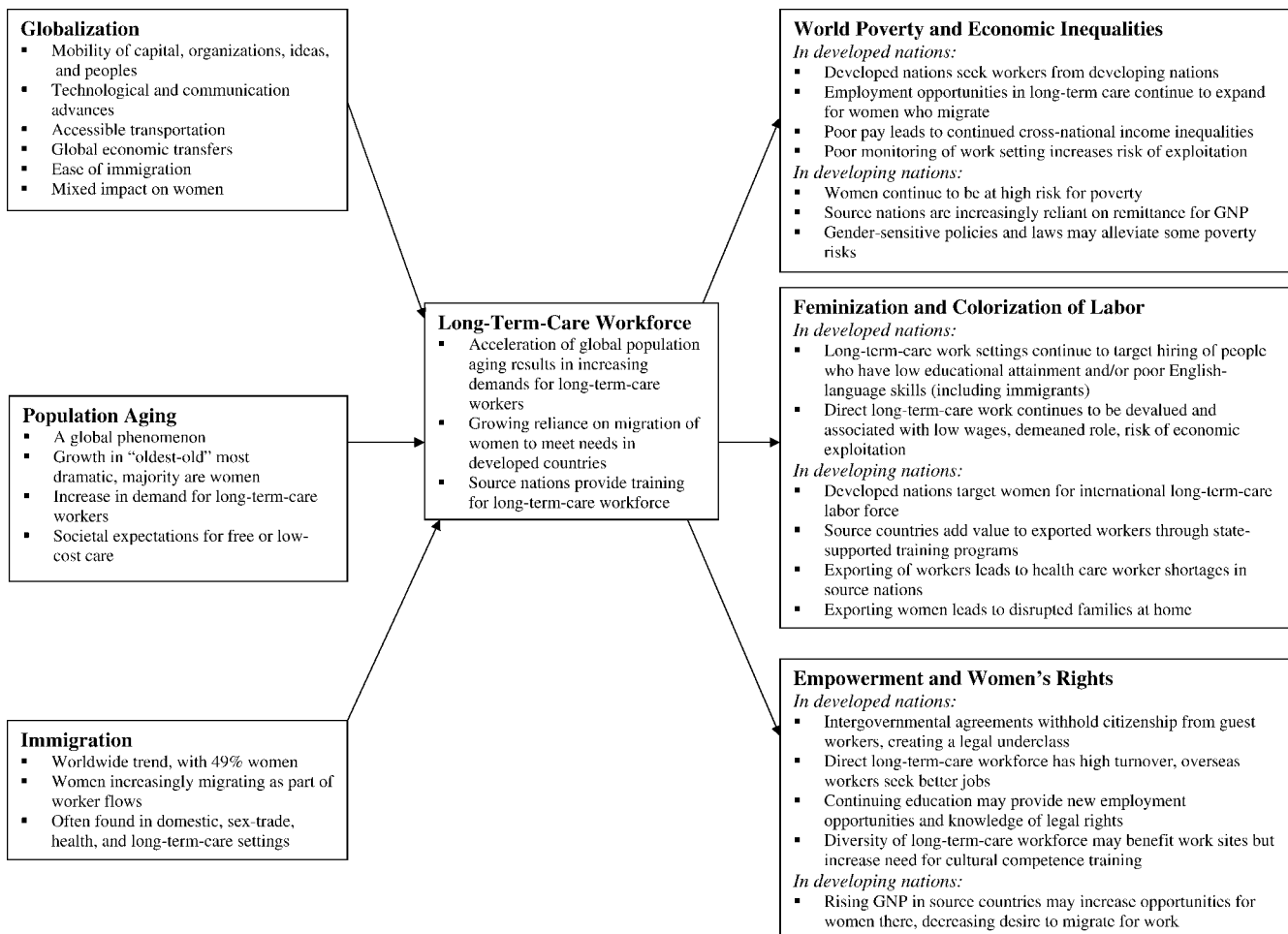


Figure 1. Conceptualization of population aging, globalization, migration, and the long-term-care workforce. GNP = gross national product.

number men in every age group, most notably in the later years, and in nearly every country. Biological and social sciences have identified numerous reasons for gender differences in longevity (Hooymann & Kiyak, 2006). This gender differential impacts health status and functioning, marital status, family caregiving, living arrangements, economic and poverty status, and the workforce (Kinsella & Phillips 2005; United Nations, 2005). Additional barriers to opportunities for women emerge when gender intersects with race, ethnicity, sexual orientation, and other statuses (Hagan, 2004; United Nations, 2005).

Globalization

Globalization, the second trend, is a complex world transformation whereby the mobility of capital, organizations, ideas, discourses, and peoples has taken an increasingly global or transnational form (Moghadam, 1999). Studied from various perspectives, globalization has economic, political, and cultural components. As defined by Joseph Stiglitz (2006), *economic globalization* refers to the “closer

economic integration of the countries of the world through the increased flow of goods and services, capital, and even labor” (p. 4). People are becoming increasingly interdependent on one another in what they produce and what they purchase, although not equally across borders. Numerous aspects of globalization impact the DLTC workforce, including poverty in developed, developing, and transitioning economies and the use of immigration policy to alleviate shortages in particular occupations.

Any discussion of globalization must acknowledge the international debt crisis and payment conditions directed at debtor nations by the World Bank and the International Monetary Fund. Strategies defined to alleviate the debt of poor nations include the enforcement measures of fiscal austerity, retrenchment of social and health care spending, and international trade agreements that rarely if ever benefit the developing nations (Blim, 2005; Stiglitz, 2006). This “crisis of development” distributes the economic benefits of such policies unequally to some parts of the world, leaving others with high social and environmental costs and disproportionately impacting women in their role as caregivers (Rankin, 2004). To

help meet their debts to international institutions, many third-world nations encourage women into four gendered production networks: export production, sex work, domestic service, and microfinance income generation (Pyle & Ward, 2003). Growing numbers of immigrants are seeking a better life in another country; increasingly, they are women (Arya & Roy, 2006; George, 2005).

Women's Migration

Migration across international borders is the third trend. As of 2000, about 159 million persons were classified as voluntary migrants, and refugees composed another 16 million (United Nations, 2003). Over the past decade alone, more than 1.5 million persons crossed international borders. The United States is the largest recipient of international migrants, with 35 million migrants in 2000, followed by the Russian Federation (13 million), Germany (7 million), the Ukraine, France, and India (United Nations, 2005). In addition to globalization forces, reasons for migration include world poverty; readily accessible/affordable transportation; the revolution in communications; growth in transnational communities; increased demand for workers; changes in immigration policies; and growing worker networks composed of families, communities, and institutions. Of the 159 million international migrants, about 90 million (49%) are women or girls (United Nations, 2005). The proportion of female international migrants is 51% in more developed regions and 54% in the United States (United Nations, 2003). Women historically migrated as dependent family members but today are increasingly part of transnational worker flows, moving to earn more money (United Nations, 2005).

Immigration data usually are not published by age or gender, making it difficult to assess the full implications of international migration for women and their employment picture. Migration research on the specific livelihoods of migrant women has only recently received more focus (Arya & Roy, 2006; George, 2005; Oishi, 2005; Olwig & Sorensen, 2002). Existing data tell us that most women migrants are employed in traditional female occupations of domestic work, health care, and teaching (United Nations, 2005). Looking specifically at health care and long-term-care employment in the United States, Ong and Azores (1994) found that Asian immigrants represented nearly a quarter of the health care providers in public hospitals in major U.S. metropolitan areas. Paral (2004) estimated that immigrants employed in health care in the United States compose 17% of the DLTC workforce but only 12.4% of the total population. In general, immigrants are employed in low-paying and insecure jobs. Women's unemployment rates are higher than men's everywhere, leading to a feminization of poverty among

those women who immigrate for employment (United Nations, 2005).

Turning to the limited data on international workers and immigrant women employed in the DLTC workforce, Redfoot and Houser (2005) identified the primary source (or supply) nations for DLTC work in the United States as Jamaica, Mexico, Haiti, Puerto Rico, and the Philippines. Most researched is the Republic of the Philippines, which has emerged as a major resource for the long-term-care workforce in the United States, Canada, Europe, Asia, and the Middle East (Chang & Ling, 2003; Oxman-Martinez, Hanley, & Cheung, 2004). Reasons for Filipina predominance in foreign long-term-care industries include the continuing high levels of poverty in the Philippines and the country's response to changing world labor markets and national pressures for foreign exchange (Tyner, 1999). It was estimated that in 1994, a third of Filipinos lived on less than U.S. \$1 per day, the standard for abject poverty (Balisacan, 1994). In 2001, the government of the Philippines announced that the poverty rate had declined to 24%, but this was primarily due to the lowering of the poverty cut-off rate to U.S. \$0.69 per day. The solution for many in the Philippines is migration. Of the country's 89 million people, 10% live abroad (DeParle, 2007). Supporting a family member to work outside the country so that he or she can send home foreign currency is a common way to prevent poverty, supplement a family's income, and afford education and property.

The Philippine government relies heavily on foreign currency sent home by Overseas Filipino Workers, and governmental policies and training programs have been established to encourage the exportation of Filipino labor (Chang & Ling 2003; Marchand & Sisson Runyan, 2003; Tyner, 1999). In the domestic-helper trades, more than 150 training centers funded by the 1994 Technical Skills Development and Education Act now operate to train and channel Filipinas to be internationally exported caregivers for children and elders (Liban, 1999). Currently, about 8 million Overseas Filipino Workers (including about 5 million women) work in 140 countries. Together they remit more than U.S. \$7 to \$8 billion each year, representing about 10% of the Philippine gross national product (Laquian, 2005; Marchand & Sisson Runyan, 2003; Pratt, 1999).

In the absence of a national database on DLTC immigrant workers, a number of smaller studies provide us with a picture, albeit limited, of the lives of Filipina domestic workers in the United States. In California, where 52% of U.S. Filipinos reside, Tung (2000) found an extensive network of Filipina migrant workers as providers of in-home eldercare, estimated to comprise 75% of all such providers in Los Angeles. These women, even if legally residing in the United States, were not licensed or registered to provide eldercare, thus adding to the challenges of

studying them. Most were paid “under the table,” a few had health insurance, none owned homes in the United States, and all planned to return to the Philippines. On average, these women remitted 75% of their income to families in the Philippines to increase their own family’s standard of living.

In Hawai’i, Filipina immigrants compose 95% of care home operators (licensed long-term-care providers who care for frail elders in their own homes). When asked why they chose this field, most noted that eldercare fit with their cultural values of respecting and caring for elders. They also noted economic reasons: They had limited opportunities for other work, and this job helped them buy a house and educate their children. Cultural values aside, they did not wish for or expect their children to continue in DLTC work because it was physically demanding and low paying (Browne, Braun, & Arnsberger, 2007).

Broadening the Discourse Around Long-Term Care as a Global Issue

The global trends of population aging, globalization, and gender migration individually and together expose the growing demand for a long-term-care workforce in the United States and other nations. As noted previously, numerous factors influence the supply of DLTC workers, including economic conditions that influence employment choice; demographic factors such as gender and fertility rates; and political decisions about immigration policy, social funding, and occupational training options (U.S. DHHS and U.S. Department of Labor, 2003). Still, most nations continue to approach long-term-care workforce issues individually, with scant attention to the effects of global aging and globalization.

What are the advantages and disadvantages of relying on immigrant women to provide needed care to a growing frail older adult population? What about the women who migrate and provide this care—what are their opportunities and challenges? And what are the effects on source nations that are providing workers for DLTC? To shed light on these questions, we turn to the insights of a number of gerontology, globalization, and immigration scholars who have grounded their work within a feminist and gender analysis. The common theme in these analyses is the quest for gender justice and the elimination of power inequities inherent in present structures for men and women, both within nations and across international borders. In gerontology, scholars have applied these critiques to issues of family care across the life course (Calasanti & Slevin, 2001; Hooyman & Gonyea, 1997), long-term care (Nussbaum, 2002; Olson, 2003), social welfare policies (Browne, 1998; Estes, 2000), retirement (Richardson, 1999), and financial security (Gonyea &

Hooyman, 2005). Likewise, a number of globalization and immigration scholars have integrated their feminist and gender analyses into critiques of the varied and intersecting relations of global power on women’s well-being (Beneria, 2003; Eschle, 2004; Espiritu, 1999; Marchand & Sisson Runyan, 2003; Parrenas, 2001; Pessar 1999; Pyle & Ward, 2003; Rao & Kelleher, 2003; Tyner, 1999).

Fundamental to a feminist analysis of long-term care and work policies is the understanding that caring work—whether paid, low paid, or unpaid—cuts across the personal and political boundaries of family, employment, and government and economic policy (Beneria, 2003; Chang & Ling, 2003; Eschle, 2004; Hooyman & Gonyea, 1997). Nussbaum (2002), in her well-framed essay *Long-Term Care and Social Justice*, reminded us that caring is considered women’s work and, although necessary for society, is poorly compensated (if at all) and undervalued. In devoting time to caregiving, women are hindered in education, employment, and political participation. Noting an “acute” lack of justice in long-term care, Nussbaum stated that “care must be supplied to those who need it, without exploiting the givers of care . . . at present, in all nations of the world, this difficult social problem has not been solved” (p. 39). Moghadam (1999), in turn, is a globalization scholar who has examined the social-gender effects of globalization with attention to their contradictory effects on immigrant women in the workforce. For good or bad, Moghadam argued, women’s involvement in the global economy has modified gender relations and ideologies, “leading to the co-existence of both vulnerabilities and sources of empowerment for immigrant women in home, work, and community settings” (p. 386). Borrowing ideas from Moghadam and other scholars, we discuss three thematic areas and their relationships to the international trends of population aging, globalization, and immigration that have import for the long-term-care workforce. These are world poverty and economic inequalities, the feminization and colorization of labor, and empowerment and women’s rights.

World Poverty and Economic Inequalities

World poverty and inequalities sharply influence the consequences of global aging and increasing demands for DLTC workers (Arya & Roy, 2006; George, 2005; Tulchin & Bland, 2005). Internationally, the risk and prevalence of women’s world poverty and desire for social and legal rights will continue to fuel the increase in their motivation for migration and for work. And although some women migrants are educated, others with limited skills work as domestics, in textiles, and in long-term care. The world’s situation, however sobering, may

appear at first glance to have a silver lining for those in developed nations seeking to hire DLTC workers.

Migration, as we have discussed, is a poverty-reduction strategy that allows DLTC immigrant workers to send money home in the form of international remittances; this may be the most effective or only way to improve the lives of their families. Living austere as immigrants, many immigrants hope to return home to a better life made possible through their savings. However, the migration of nurses, nurse aides, and other long-term-care workers, who are primarily women, leaves serious health care shortages in source countries like the Philippines (Laquan, 2005).

Would improvements in the economies of source countries lessen migratory trends? Changes in land ownership laws in Nigeria and Rwanda now allow women to inherit land. Women in Bangladesh enjoy expanded employment opportunities due to the growth of the export garment industry and have organized labor unions to strengthen their bargaining power (United Nations, 2005). The Grameen Micro-Credit Bank in rural Bangladesh is another positive example. Gender at Work, a knowledge- and capacity-building network for women, cites examples in India, South Africa, and Latin America of strategic interventions developed to provide for better accountability to protect women's economic interests (Rao & Kelleher, 2003). This is good news, but it nonetheless exposes the fact that when conditions within source countries improve, the need and drive to migrate may diminish.

Feminization and Colorization of Labor

Occupational segregation by gender and race is an institutional feature of the U.S. workforce overall, and long-term care is but one example. In the United States and other nations, eldercare remains the charge of women, either as unpaid caregivers or as low-wage DLTC workers (Friedland, 2004; Stone, 2001). In both developed and developing nations, a gender-specific labor supply is produced by gender and cultural norms and stereotypes, through which certain occupations, such as nursing, are defined as more suitable for women. Gender-specific expectations further encourage immigrant women to send money back to families via remittances. The present anti-immigration stance of some Americans also may contribute to the devaluation of eldercare as a profession, as eldercare so often employs immigrant women. These factors help maintain relatively low wages for DLTC workers.

Returning to the case of Filipinas as DLTC workers, research in ethnogeriatrics has explored cultural values that support family caregiving (Braun & Browne, 1998; McBride & Parreno, 1996). Findings can be misconstrued to suggest that women in some cultural groups, like Filipinas, are natural caregivers

because of their cultural values to respect and care for elders. Conservative theorists have posed the comparable argument that Filipinas are natural nurturers in order to describe women's similar natural roles as unpaid caregivers in most male-dominated societies. In the end, this argument may legitimize the low pay of DLTC workers by arguing that it is the nature of women and of certain cultural groups to provide this work. In contrast, evidence suggests that many migrant women choose care occupations because globalization, international economies, training opportunities, and immigration policy encourage them in this direction (Oxman-Martinez et al., 2004; Tung, 2000).

Economic pressures intersect with gender and cultural expectations to increase migrant women's vulnerability to employment exploitation (Chang & Ling, 2003; Espiritu, 1999; Hagan, 2004; Oxman-Martinez et al., 2004; Parrenas, 2001; United Nations, 2005). Migrant women working as carers are especially vulnerable to exploitation because domestic service is often paid under the table and, as such, local labor laws may not be enforced (Pratt, 1999). Sexual exploitation is not unusual; workers talk of "laying down" or being "laid off" (Sharma, 2003). Unfortunately, women subject to abusive employment practices may find that supply governments are reluctant to intervene because of their dependence on overseas worker remittances (Pyle & Ward, 2003). At the same time, labor market restructuring is developing foreign employment situations in which immigrants and immigrant women are denied rights or entitlements of citizenship in some demand (destination) countries (Oxman-Martinez et al., 2004; Sharma, 2003). At a microanalysis level we wonder: Who is responsible for immigrant women's social and economic well-being? And at a more macro level we ask: Do developed nations owe a debt to those nations whose workers migrate after receiving health-related training? Who should pay this debt? A World Health Organization (2002) report posed this question: "Is it reasonable to ask if the multinational corporations that depend on the natural and human resources in developing countries have a responsibility to fill the gaps in caregiving they help to create?" (p. x).

Empowerment and Women's Rights

Low pay is but one consequence for migrant women of being employed in gender-specific work (United Nations, 2005). Another may be enhanced autonomy and empowerment. Nonetheless, and as we show in Figure 1, empowerment and women's rights hold different implications for women in developed and developing nations. Studies have found that immigrant women choose DLTC work because it allows them to care for their own families, calling for a greater theoretical understanding of the com-

plex ways in which home and family are situated differently by groups of women (Browne et al., 2007; Collins, 1991; Parrenas, 2001).

Although increasing scholarship and policies have focused on the provision of cultural competence for the consumer, limited attention has examined the need for cultural sensitivities for the DLTC worker from other nations. Immigrant workers face numerous issues related to acculturation that influence their integration into the DLTC workforce and U.S. society (Hoppe, 2005). Prejudices and discriminatory behaviors and attitudes based on nationality, race/ethnicity, class, gender, and other sociodemographic factors exist in the greater community, and it would be naïve to think they disappear in the long-term-care setting (Aronson & Neysmith, 1996).

Parker and colleagues (Better Jobs, Better Care, 2006b) identified a number of problems related to diversity among staff and residents in long-term care, such as difficulties with communication, discriminatory attitudes and behaviors, and organizational nonresponse to these problems. Varied cultural competency interventions were implemented and evaluated, with the results linking training to beneficial effects on employee attitudes. The authors argued that cultural competence training be mandated for all staff (including supervisors) and residents and its delivery monitored by government.

From a strengths perspective, programs that serve older adults may well find that immigrant women, in contributing to the diversity of their workforce, can be resources in program delivery, training, and marketing. By 2050, 1 of every 4 older adults in the United States will be a member of an ethnic minority group (U.S. Department of State and U.S. DHHS, 2007). As the nation's aged population and those who work in DLTC become more ethnically and culturally diverse, the potential exists for each to teach the other about cultural awareness. Although few would argue against continuing education for eldercare workers or the protection of their legal rights, worker empowerment may lead to increased awareness of opportunities to choose another career or work path as long as DLTC work is poorly paying and stressful.

Practice, Policy, and Research Implications

For elderly citizens to have access to a quality long-term-care workforce, the work must adequately compensate and protect those who provide it. The issue of compensation is especially critical for immigrant women who are working not only for themselves but for their families back home. In all, 22 states have enacted the wage pass-through—a new policy strategy that allocates additional Medicaid funds to pay for higher DLTC staff wages. Data on the effectiveness of this policy are not yet available, and decisions that individual states are making about amount the size of the salary increase,

to whom it is targeted, and accountability systems will likely yield different results across states (PHI, 2003). In addition to increased wages, other retention factors include health care benefits, opportunities for career advancement, education about legal rights, and respectful working conditions (Better Jobs, Better Care, 2006a; George, 2005). An international analysis can suggest new policy directions for the United States. For example, Canada's government-sponsored Live-in-Caregiver Program facilitates the migration of workers who live with and provide care to a child, an elder, or a disabled person in a government-approved home. The government provides a valid work permit to those eligible, and workers may apply for permanent residency after 2 years with the same employer. Although the program has its supporters, Oxman-Martinez and colleagues (2004) suggested that the program's requirements tie workers to a single employer for 2 years, making them vulnerable to exploitation and abuse.

In the United States, a new pilot program of the Department of Labor aims to provide career advancement opportunities via a nursing career ladder that will link nurse aides to apprenticeships, community colleges, and professional nursing programs (Chao, 2007). The passage of the Workforce Investment Act of 1998 also aims to provide DLTC workers with career opportunities for higher wages and career advancement by connecting workforce training and development to local and regional engines of economic growth (Better Jobs, Better Care, 2006a; Health Workforce Solutions, 2006). Both offer the potential for better work conditions and opportunities for some immigrant DLTC workers. Creating safe and respectful working conditions for these women also requires knowledge about their legal rights and freedom from prejudice and discrimination in the work setting and beyond (American Health Care Association, 2005; Lowell & Gerova, 2004). The need for legal education and training in cultural competence, then, must be a two-way street—both the worker and the consumer will benefit from knowledge on rights and responsibilities of all workers and increased sensitivities to diversity. Employers in both public and private long-term-care organizations must balance their need to recruit good workers with a consideration of the rights (e.g., to a comfortable wage) of those who provide this care.

Macrolevel issues include fairness and unresolved policy issues around questions of global social justice for both source and destination nations. There may be a lack of consensus regarding some of these issues, and the dictating of policies may be premature. Nonetheless, we join scholars like Redfoot and Houser (2005) in raising a number of research questions that raise our awareness and deserve our attention. For developing nations such as the Philippines, we ask about the social costs of this migra-

tory pattern on workers' young children and elderly parents who remain in the source nation. Should migration policy allow source countries to reduce their capacity to deliver equitable and accessible health services? And to what extent will these migratory patterns jeopardize future generations of citizens in these source countries? For developed countries like the United States, can salaries and benefits for all DLTC workers be increased, and, if they are, will others (men and women) enter this profession? Will labor shortages cease to exist? And how much will increased salaries impact the already high costs of long-term care? Should destination countries impose regulations on recruiters who seek DLTC workers from source nations? And, finally, do developed nations who benefit from securing these workers from developing nations have a responsibility to address the health care problems of the countries that are losing these workers? Most important, more data are needed on foreign-born DLTC workers, especially those working in home settings where conditions are hard to monitor.

Conclusion

In this article, we examined the potential impact of international trends around population aging, globalization, and women's migration on the DLTC workforce. We presented evidence that the increase in the aging population is unprecedented and global, that world poverty and immigration are on the rise, and that the need for DLTC workers is increasing. We suggest that researchers continue to critically consider our present strategy of relying on compensatory migration, primarily of women, given these global trends. We raised questions in three thematic areas—world poverty and economic inequalities, the feminization and colorization of labor, and empowerment and women's rights—suggesting avenues for practice, policy, and research. In the end, and regardless of the nativity of eldercare providers, it is in each nation's best interest to acknowledge that long-term care has become a global issue and that dignity and caring belong on both sides of the equation.

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