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Women, Migration and the Work of Care: The United States in Comparative Perspective

Introduction

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In most societies, responsibility for care—of children, the elderly, and those living with chronic illness or disability—has traditionally been assigned to women. Today, however, the gendered division of labor is being reordered worldwide. Since the 1990s, women's shift into paid labor in countries around the globe has strained their capacity to care for their families. The "care deficits" produced by this shift present a challenge to individuals seeking to reconcile work and family, as well as to national policymakers who must balance demands for care with those for equal opportunity for women, and for the full development and utilization of human capital. This issue also has a marked transnational dimension, as "global care chains" increasingly draw women from poorer nations to take up paid care work positions in richer ones, producing not just care deficits but "care drains" from sending countries.

Over the past decade or so, care deficits have become markedly visible in the United States, where female labor force participation has been high (nearly 60 percent) and the demand for care is on the rise due to the aging of the baby boomer generation. Now shouldering responsibility for the care of elders as well as children, many wage-earning women are forced to look outside their families for help. The U.S. government, long a laggard in terms of welfare provision, has little to offer in the way of public care, but commercial and even non-profit services are often prohibitively expensive. As a result, families are increasingly turning to the

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informal private labor market to find caregivers. And much of this demand is being met by migrant women workers.

The United States is not the only advanced market democracy currently facing care deficits, so it makes sense to examine the policies surrounding women, migration and the work of care in comparative and transnational perspective. The papers that follow are based on presentations given at the conference "Temporary Migrant Care Worker Programs in Canada and Europe: Models for the United States?" which was held at the Wilson Center on May 12-13, 2011. The authors address three sets of questions: What are working conditions for migrant caregivers in "destination countries," and how are they affected by the immigration laws and regulations of those countries? How does women's migration affect family members left behind as well as their own wellbeing? And finally, what is the current legal context for caregiver migration to the United States, and what are the political prospects for reform?

Immigration Regulation and the Care Labor Market

Scholars of migration, both historical and contemporary, attribute migration trends to "push" and "pull" factors, both of which are highly contingent and change over time. When it comes to care workers' migration, current push factors include the need for income coupled with a lack of job opportunities for women in countries of origin, while the strongest pull factor is the demand for a kind of labor with which women are closely identified.

Caregivers' working conditions are difficult at best; the work entails isolation in private households, low wages and low status. Moreover, because the jobs are "informal," they generally lack protection under conventional labor laws. For migrant caregivers, there are added problems: the sense of dislocation endemic to working abroad and often the danger of having entered a country illegally. Many developed states, including the U.S., restrict immigration to skilled or professional workers, thereby excluding potential caregivers, who are classified as "unskilled." Those who persist and take jobs without authorized entry documents become vulnerable to exploitation and abuse, but are reluctant to protest, lest they risk deportation.

In the United States and elsewhere, the incongruence between the high demand for care workers and low annual immigration quotas for unskilled workers has produced significant cohorts of unauthorized workers. A few countries have responded by changing their immigration laws. Spain, for example, has intermittently opened its gates to low-skilled workers (Associated Press 2008), while Italy recently offered amnesty to all undocumented migrant care workers present in the country (ABS-CBN News 2009). Canada and Austria have taken a more measured approach, setting up temporary care work and circular migration programs respectively, while Germany has an unofficial policy of "state compliance and complicity" that allows "irregular" migrant caregivers to work more or less without interference. These latter three cases are the subject of the first pair of papers in this report, by sociologists Monica Boyd and Helma Lutz.

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Care across Borders

Women's migration has multiple implications for those left behind. While remittances (the money they send back) are often essential to their families' wellbeing—sometimes to their very survival—women's absence also means that they are no longer available to provide accustomed forms of care. In her paper, ethnographer Leticia Robles-Silva describes both how the elderly relatives of migrants in one Mexican city have been affected and how migrants, along with those who remain at home, construct "transnational parent-care systems." Looking at migrants on the other side of the border, public health researchers Xóchitl Castañeda and Magdalena Ruiz Ruelas point out that most of the women who care for American children and elders lack access to health care themselves. This means that aged, ill or disabled migrants must return to their countries of origin when they are

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in need of care, thereby increasing pressure on the social infrastructure in those countries.

Policymakers are becoming increasingly concerned about the relationship between migration and development, but they tend to overlook its gendered dimension (see OECD 2007 and Center for International Development 2011 for examples). The care drains that result from women's absence can undermine international efforts to promote development through improving child health, nutrition and educational attainment. To be sure, women's remittances help families pay school fees, cover medical costs, build better houses and perhaps start small businesses. But money only goes so far. Without women on hand to prepare nutritious meals, ensure children's school attendance and take them to clinics, it is difficult for families in the poorer countries to respond to an ambitious agenda like the one set out in the United Nation's Millennium Development Goals (UN 2011). The governments of the sending countries are seldom in a position to compensate (either institutionally or financially) for the loss of women's caring labor, so families must improvise, and their efforts meet with mixed success.

Prospects for Reform in the U.S.

The papers by Lutz and Robles-Silva indicate that when migrant women workers are able to move freely across borders, they can much more easily handle transnational care responsibilities. Indeed, as Lutz has found, East European migrants working in Western Europe have established a recognizable pattern of circular migration facilitated by proximity, access to low-cost transportation, and the ease of traveling and working within the EU. While not ideal, it allows these women to regularly tend to their families' needs at home while engaging in paid care work abroad. The Canadian Live-in Careworker Program discussed by Boyd does not provide for circular migration but it does hold out the prospect of permanent residency, eventual citizenship and family re-unification.

Would either approach work in the U.S.? This is the question posed to two experts from the Migration Policy Institute, Muzaffar Chishti and Margie McHugh. Chishti answers by pointing out the limits in existing immigrant laws and regulations, while McHugh focuses on the political obstacles to achieving reform. The United States has had temporary worker programs in the past, most notably—and notoriously—the one that brought in the Mexican braceros in the 1940s, fifties, and early sixties; however, that legal and regulatory space no longer exists. Nor is there much political space for change within the current polarized climate in Washington. McHugh, taking her cue from Canadian provincial policy, proposes that state policymakers experiment with pilot programs to bring in immigrants to meet local needs.

A Transnational Question of Care

Whatever progress the United States is able to make, righting the global mal-distribution of care labor—the tilt from the developing to the developed world—will ultimately require global governance. Ideally, migration flows would be regulated and synchronized equitably with care needs at both ends of the global care chain, but in the meantime, destination countries should find ways to compensate countries of origin for the loss of women's contributions to their families and, more broadly, to their communities and societies as a whole. NGOs have set up a few small-scale projects along these lines in Romania and the Ukraine (Piperno 2007), but far greater resources will be needed to make a meaningful difference. International and national organizations, including both state and non-state actors, as well as market actors, must become involved. ▮

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Bringing Care Workers to Canada: Canada's Migration Policies

Monica Boyd

Canada's low rate of natural increase (0.4 percent) means that it must look to international migration not only to enhance population growth and stimulate the economy, but also as a source of labor. These efforts rest on two pillars: permanent and temporary recruitment of migrants. In the recent past, most migrants were admitted as permanent residents, meaning that visas permitting entry also granted residence rights. The criteria for permanent admissibility rest on humanitarian concerns, family reunification and economic contribution, with the latter criterion dominating from the mid-1990s. Migration policy changes during the past decade now also encourage numerous temporary migrant workers. By 2010, two thirds of all permanent resident admissions consisted of workers and their immediate families in the economic class. However, the number of temporary workers was slightly greater than the total admission of permanent residents; in December 2010, 282,771 temporary workers were living in Canada compared with the 2010 admission of 280,681 permanent residents.

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Female care workers come to Canada under the auspices of these two migration policies, primarily as health practitioners or as care workers in private households. Like many OECD countries, Canada actively seeks health practitioners. As permanent residents, these health practitioners can be admitted as refugees, as family members joining relatives already in Canada, or as part of the economy-based entries. Within each of these "classes of admission," they may enter as principal applicants or as accompanying family members. Physicians, supervisory and registered nurses and practical nurses are especially sought after as skilled workers in the economic class. In February 2008, the Minister of Citizenship and Immigration announced procedural changes that restricted the permanent admission of skilled workers (and immediate family members) to those with work experience in 38 out of 520 specific occupations (Citizenship and Immigration Canada 2008); in June 2010 the list was modified to include only 29 occupations (*Canada Gazette* 2010). Specialty and general physicians, head nurses and nurse supervisors, registered nurses and practical nurses are on these lists.

A Preference for Women Care Workers

Although women make up less than half of foreign trained physicians entering Canada in recent years, they predominate among those with nursing-related occupations. However, current intake through deliberate recruitment in the economic class is small. During 2002-2005, approximately 1200 nurses entered as permanent residents, either in the skilled worker category or as provincial nominees (through a program in which provinces take responsibility for admitting workers). Nonetheless, a longer time horizon suggests that migrant nurses are a small but significant proportion of the nursing profession (Bourgeault et al. 2010). Almost one third (31.2 percent) of all internationally educated registered nurses come from the Philippines, followed by the United Kingdom at 17 percent and the United States at 6.6 percent.

Additionally, care workers may enter as temporary workers. To do so, health practitioners must have offers of employment and a positive assessment of the need for their labor. These conditions are demand-driven: would-be employers petition Service Canada for a positive Labour Market Opinion (LMO), which assesses the impact the foreign worker would have on Canada's labor market (i.e., how the offer of employment would likely affect jobs for Canadians). Hospitals and care facilities are important agents in generating this demand. Reflecting this venue, nursing was among the top ten occupations given LMOs; in 2008 and 2009 respectively, 1843 and 1628 nurses were granted LMOs by Service Canada.

Women also may enter Canada temporarily as care workers in private homes. Reflecting a long history of recruiting female domestics under various migration policy initiatives (Boyd 2011), the current Live-in Caregiver Program (LCP) is also demand-driven. Would-be employers petition for the temporary admission of caregivers under LMO procedures, which also assess the caregiver application to ensure that the requirements of the program are met. In effect since 1992, the LCP stipulates that a caregiver must have at least a high school equivalent completion, six months training or one year of experience as a caregiver or in a related field (such as teaching or nursing), good knowledge of English or French (Canada has two official languages), *and* must live in the home of the employer.

Currently the majority of live-in caregivers are hired to look after children and undertake household work such as cleaning and cooking. Most of today's LCP workers come from the Philippines. The predominance of Filipinas reflects a number of factors, including the culture of migration that accompanies the encouragement of emigration by the Philippine government, employer demand based on racialized preferences and images of Filipinas as family-loving and docile, and the Filipino educational system, which makes it easier for applicants to meet the LCP educational and language requirements (Boyd 2011).

Although the Live-in Care Program is significant in policy terms (see the next section), the number of temporary worker visas is relatively small. Between 2000 and 2009, the number of entry visas issued annually in this program ranged from a low of nearly 2,700 to a high of almost 14,000 in 2007. These entries represented 2.3 percent and 6.7 percent of the entry visas issued to all temporary workers in these two years.

The Problems of Entering via the "Back Door"

The programs that admit women as nurses and home-based caregivers offer these temporary migrants the potential to become permanent residents. As of September 17, 2008, the Canadian Experience Class (CEC) provides a mechanism for temporary health practitioners to change their status. The CEC allows an applicant's experience in Canada to be considered as a key selection factor when immigrating as a permanent resident. In addition to other requirements such as the successful completion of a language test, a foreign worker must have at least two years of full-time Canadian work experience in managerial, professional or technical occupations or skilled trades to qualify for the program.

Under the regulations governing the Live-in Caregiver Program, workers may apply for admission as permanent residents after they have completed a stipulated length of time working as caregivers in private homes. In order to petition for permanent resident status, until April 2010, Live-in Caregiver workers were required to have 24 months of full-time domestic work within a three-year period, as well as a clean criminal record and satisfactory medical examination. As of April 2010, the three-year period was extended to four years. LCP workers also now have the option of becoming eligible after 3,900 hours of work over a minimum of 22 months in which a maximum of 390 overtime hours may be counted. In recent years numbers have increased substantially, up from 1,760 principal applicants in 2000 to 6,273 in 2009.

These transitioning options represent a "back door" (literally as well as figuratively) through which women from less developed countries may be able to obtain permanent residence status in Canada. As well, some women in the health professions may be able to enter directly via the economic class and thus bypass the temporary work back door. Others also may immigrate on humanitarian or family reunification grounds.

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Occupational Woes

However diverse the modes of entry, problems exist for many of these caregivers. For women who bypass entering Canada as temporary workers and have trained as health practitioners,

re-accrediting according to Canadian professional standards emerges as a major barrier to working in their chosen fields. Many professions, including those in health care, are regulated in Canada, meaning that professional associations are provincially mandated to ensure that workers conform to existing training standards and preserve public safety. Kolawole (2009) lists seven requirements that internationally educated workers must fulfill in order to be employed as registered nurses, including completion of an acceptable RP or registered practical nursing educational program, a record of recent safe nursing practice and language fluency. Meeting these criteria can be difficult for internationally educated nurses for any number of reasons: the impossibility of getting diplomas for those who have had to flee persecution or civic unrest; the variability in nursing standards across countries; language proficiency issues; and the fact that nursing practice must have been achieved in the last five years.

Accreditation standards also pose difficulties for internationally educated nurses who come to Canada as temporary workers. Additionally, because LMOs are generated by employers such as hospitals and care institutions, internationally educated nurses may be recruited to work in nursing-like jobs but not as registered nurses. The mismatch between actual training and employment carries the potential to influence subsequent petitions for permanent resident status. Since the Canadian Experience Class is targeted at skilled workers, de-skilled workers in less skilled jobs may find they are not eligible for this program if they have worked in occupations not considered "skilled."

The problems experienced by migrant women who work as caregivers in private dwellings have been well-documented and continue to be of concern. First, these women are the constitutive elements of "global care chains" that enable class-privileged women to purchase care resources from economically disadvantaged women (Hochschild 2000, 2008) who, in turn, purchase care for their children and elders from women who are even more disadvantaged in their origin countries. Second, these migrant domestic workers frequently experience a rendering of social and maternal bonds and become caught in the dynamic of transnational mothering (Yeates 2004). Third, because of the close proximity to the "boss," paid caregivers are subject to the personal authority of their employers with little recourse to bureaucratic rules and regulations that govern disputes. They are at risk of mental and physical abuse as well as sexual assaults.

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Other problems exist for migrant workers in the Live-in Caregiver Program, including actions undertaken by recruitment agencies; unscrupulous employers; and difficulties in meeting criteria for permanent residence. The first two originate from a paradox: the federal government is responsible for immigration policy changes, but the provinces are responsible for regulating labor. All three problems have received considerable media attention within the past two years, and they have been the subject of lobbying efforts by non-governmental organizations (NGOs) concerned with the treatment of the live-in caregivers. Within the past two years a number of policy initiatives have been developed to target these problems, including federal and provincial legislation to regulate recruitment agencies that charged exorbitant fees, could (unlawfully) ask domestic workers to pay fees and transportation costs, and even recruit workers for jobs or employers that did not exist (Boyd 2011). As well, the Canadian federal government has recently revised requirements that attempt to prevent employers from obtaining unpaid overtime work, or to engaging in faulty record-keeping that can jeopardize an LCP worker's attempt to meet the requirements of applying for permanent resident status. As noted earlier, the federal government also has implemented a four-year window instead of the three-year period for accumulating the necessary months or hours of domestic work.

A final problem of deskilling remains more elusive to change. Given the increasing human capital component of the LCP, highly educated female workers are now being recruited who trained originally for teaching, nursing, engineering and other skilled jobs. During their employment as live-in caregivers, however, these women are effectively diverted from these occupations and at least two years, if not more, go by with no job experience in jobs that correspond to their original training. As a result, upon receiving permanent admission to Canada, live-in caregivers may not find employment that matches their original training, particularly if ongoing experience or accreditation is required. For both live-in caregivers and internationally educated nurses who are admitted under Canada's larger temporary worker program but work as practical nurses or in other health occupations, the potential for deskilling is one that requires additional investigation and future policy initiatives.

The Future

Because they are new initiatives, it is too early to tell if recently implemented changes will mitigate the difficulties experienced by temporary workers in the LCP. Challenges within the program remain, many of them rooted in the live-in requirement that makes workers highly vulnerable to employer behaviors and decisions as well as in the requirement that caregivers accumulate two years in such jobs, often performing work that differs from the occupations for which they originally trained. Given the stated purpose of the program, however, it is unlikely that the federal government will remove these requirements. In addition, the re-accreditation difficulties of health practitioners and other professionals remains a core concern but not one that is amenable to direct manipulation by the federal government. Provinces have the responsibility of creating and enforcing labor standards and mandating professions to train their practitioners. As a result, federal initiatives have taken the form of funding a foreign credential recognition program within Human Resources and Skills Development Canada; this program funds small pilot programs and stimulates awareness and dialogue.

Continued policy attention is likely in the years ahead, stimulated by the aging of the Canadian population. Canada still has one of the lowest proportions of seniors among the OECD countries with 13.9 percent of the 2009 population aged 65 and older. But numbers will dramatically increase with the aging of baby boomers (those born between the late 1940s and the early 1960s) along with the impacts of past and present cohorts whose fertility has fallen below replacement levels. The percentage of seniors is expected to double in the near future, ranging between 23 and 25 percent in 2036 (Statistics Canada 2010). The eventual health problems and frailty of these seniors will require additional medical personnel and personal caregivers. In the absence of other domestic policy changes in the caregiving arena, the demand for female caregivers migrating either permanently or temporarily to Canada will only increase. ▮

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Circular Migrant Domestic and Care Workers in Germany and Austria

Helma Lutz

Circular migration between East European sending and West European receiving countries has been a common pattern since the transition of the Eastern Block in 1989. This began as a self-organized migrant rotation system (e.g. in seasonal agricultural work and in domestic work) between pairs of neighboring countries like Poland/Germany and Czech Republic/Hungary-Austria, but also including more distant countries such as Poland/Sweden and Poland/The Netherlands. Now circular migration has become a common pattern in many parts of Europe.

Germany, with a population of 80 million, and Austria, with eight million people, are both witnessing a rise of circular migration. Both members of the European Union,[1] the two also belong to a group of states with restrictive regulations that favor highly qualified migrants but exclude domestic/care workers. Other EU members like Italy, Spain and, until recently, the UK have established admission and recruitment policies to attract domestic workers. The German and Austrian governments, in contrast, have over the past fifteen years ignored the growing demand for domestic/care workers from abroad, with the result that in both countries a growing market for undocumented migrant care workers has emerged. More recently, both countries have moved to address this migration pattern, but each has handled this "twilight zone" differently.

Domestic Work and Familialistic Welfare States

One way to define "domestic work" is by using Bridget Anderson's (2000) "three c's" label—cooking, cleaning, and caring. This definition has the advantage of demonstrating the broad range of activities that domestic work entails. Most studies show, however, that the three c's cannot be neatly detached from one another, as caring often includes cooking and overlaps with cleaning. Therefore many scholars now prefer the term "care work," which is defined as "multifaceted labor that produces the daily living conditions that make basic human health and well-being possible" (Zimmermann et al., 3-4). In addition to physical, practical activities, care work involves emotional duties such as support, the expression of affection, kindness, enthusiasm and love—in other words, a personalized relationship between employer and employee characterized by intimacy, trust and responsibility.

In the cases of Austria and Germany—countries with longstanding conservative, "familialistic" gender and welfare regimes marked by the absence of public services—domestic/care work has been considered the unpaid obligation and domain of the housewife. Nowadays, however, as more and more adult females enter the paid labor force and are no longer available to provide fulltime care for their relatives, and an aging population increases the demand for care, families are seeking help through the market (Lutz 2011).

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Composition of the Care Market

Most of the workers currently populating the care market in Germany and Austria are migrants. In both countries, the majority of migrant workers have no legal contract, and even though both offer a service-cheque system (employment on an hourly basis through a private agency, partly supported by tax reductions), the rate of take-up is low. There are several reasons for this: employers prefer cheap and flexible labor, but since they also consider "trustworthiness" to be an important qualification for domestic

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employees, they want the kind of continuity that agencies do not provide. At the same time, migrant workers prefer a direct wage payment, rather than going through a third-party employer.

Care market employees fall into three categories[2]: domestic workers, child care providers and caregivers for the elderly.[3] Domestic workers are mostly live-out cleaners and housekeepers; 10-20 percent of all German households make use of them, while for Austria the number is 20 percent. Child care providers, by contrast, normally live in. These workers are predominantly young female "au-pairs" who immigrate on one-year contracts through a special scheme that mandates minimum wages and work regulations but provides no oversight to monitor compliance with the rules. In both countries, the greatest number of au-pairs comes from Eastern Europe (Poland, Romania, Czech Republic, Slovakia, Hungary, Lithuania, Latvia, Ukraine, Georgia, Moldavia and Bulgaria). Many regard the scheme as a migration strategy, using the initial legal entry to establish a follow-up arrangement. That is, they overstay their legal residency while maintaining working relationships with their host families and register as students in order to regularize their stays. For parents, the one-year rule can be inconvenient since it disrupts relationships that children may form with their caregivers, yet au-pairs are still the preferred choice for child care services because of their hourly flexibility and cheap monthly wage (260-350 Euros) as opposed to crèches and kindergartens, which have limited opening hours and sometimes high fees for services.

The third category, long-term caregivers for the elderly, is the fastest-growing occupational sector, with high demand rates. This group of workers, again largely from Eastern Europe live in the households of care receivers, who are also usually their employers. Notwithstanding rules and agreements on working hours, they are typically on call around the clock. The overwhelming majority are "irregular," with monthly wages ranging from 900 to 1200 €—a quarter of what a commercial home care agency would charge. In Germany, the number of long-term caregivers is currently estimated at 150,000 to 200,000. The country's regulations for elderly care indirectly promote this situation by paying a "kin-care" allowance directly to family members for taking over private home care. These family members then hire migrant caregivers to provide the actual services.

My colleague Ewa Palenga and I (Lutz and Palenga-Möllenbeck 2010) describe this arrangement as a form of "state compliance and complicity"—an attitude that is convenient for the government as it helps to solve the care-deficit problem while at the same time keeping intact the illusion of a home-caring society. Moreover, it avoids conflicts with unions and commercial home-care agencies over what a liberal care-migration policy would entail.

The Logic of Circular Migration

In the majority of the households, migrant women establish a self-organized rotation system. They spend six to ten weeks providing paid care to their employers before returning to their families. There they take over their "female" obligations as mothers and caring daughters from other women (usually grandmothers) who have been performing "their" family-care tasks in their absence. Migrants organize their own replacements to cover their duties in the households of care receivers while they are gone.

Circular migration patterns suit East European migrant women for various reasons. First of all, given the income gap between Eastern and Western Europe, the wages they can earn as care and domestic workers abroad are highly attractive, despite the lack of regulation of this type of employment. Second, circular migration allow the women to retain their main residence in their home country, leaving children and elderly family members, who are also in need of care, and partners or husbands behind. For the majority of East European women, work outside the home, along with family care, was part of their duties as members of a socialist society. During the transition to capitalism, women suffered greater unemployment than men and were compelled to search for work abroad. Thus, their relocated workplaces can be seen as a legacy of women's citizenship obligations under socialism.

At the same time, the working conditions and restrictive immigration regulations of the receiving countries, in this case Germany and Austria, do not offer these women the option of bringing their children or other family members along with them. Circular migration works efficiently because it is driven by female workers' loyalty to family members and their sense of responsibility to uphold care obligations at home, as well as a desire to maintain that home with their earnings.

The emerging pattern, then, reflects a transnational care commitment. It is, however, one that women must balance individually with the help of personal networks, since the sending states offer neither support nor services to compensate for the caring labor of absent women. Yet, despite women's efforts to maintain ties with—and care for—their families and to provide much-needed financial support, in many places, women are denounced for producing "Euro-orphans" (see Lutz and Palenga-Möllenbeck forthcoming).

Is Regularization the Answer?

For many years, both Austria and Germany had a high number of irregular migrant workers, but in 2007 Austria institutionalized the formerly self-organized circular migration system through a legal migrant care arrangement for private households. The new regulations consist of a self-employment model with direct payment to the workers complemented by social protection coverage for health and retirement contributions. The take-up rate for this scheme has been high, and it has helped to protect both employees' and employers' interests (Österle et al. 2011). Although at the time of writing (summer 2011), the German state still turns a blind eye to this sector; it is likely that Germany will replicate the Austrian model sooner or later.

Increasingly, circular migration, whether it is self-organized and irregular as in Germany or institutionalized as in Austria, is now the widely accepted answer to the care deficit in these countries. In the long run, such a scheme must be established on a legalized basis in order to avoid the emergence of second-class citizenship. But even then, there are potential downsides. First, in receiving countries regularization could serve to establish a two-tier model composed of expensive, formal home-care services that exist alongside a cheaper migrant care worker system. While employers and the state might consider circular migration a flexible tool for solving the care deficit, trade unions warn that social standards and labor rights could be eroded. Second, the recruitment of female migrant care workers from Eastern Europe leads to a growing "care drain" in the sending countries, with mixed or possibly negative repercussions for spouses, children and elderly family members who stay behind.

Circular migration can thus be seen as a second-best, temporary solution that will persist until care deficits in receiving countries and the resulting care drains in sending countries become the subject of a broad social discussion on the future of the asymmetric divide between waged and care work. ▮

> "The working conditions and restrictive immigration regulations of the receiving countries do not offer these women the option of bringing their children or other family members."

Endnotes

1 While EU member states have largely harmonized their legislation on social rights agreements, in contrast, migration regimes are dominated by the respective national states' interests.

2 See also Österle et al. 2011.

3 In both countries sound data on the scope of this market are absent; however, the Austrian estimates seem to be more validated.

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Transnational Care, Local Inequalities: Care in an Urban Poor Community in Mexico

Leticia Robles-Silva

In the analysis of transnational practices of care, two issues remain under-studied. The first is how family members in both sending and receiving countries organize care for aging parents. The second is the dual or paradoxical effect of transnational care—that is, the fact that while the social and economic aspects of caring for aging parents are generally improving, migration itself is producing social inequalities among families of the same social group or community. This paper is based on two ethnographic studies carried out in Guadalajara, Mexico. The first included families with chronically ill parents in a poor neighborhood,[1] and the second was conducted in a private nursing home with elderly residents living in poverty.[2]

Migration and Transnational Care

The aging parents in the first study migrated from the countryside to the city in the 1930s and 1940s. Their children, however, migrated both within Mexico and out of the country during the 1980s and 1990s. Forty percent of the households in my sample had at least one child who had migrated to the United States. The children chose to leave because they were young, unemployed, single and without offspring—characteristics that gave them a mobility advantage over their parents. Some children became legal residents of the United States, while others remained undocumented, but none returned to Mexico. At the time they migrated, these young people's parents were all in their 50s, and although half of them already had a chronic disease, none needed care at that moment. The need for care arose later: all of the parents in this group became dependents ten years after their children left Mexico.

To meet their parents' needs, the migrant children engaged in four cross-border caregiving practices: financial support, care remittances, distant care and paid care.

In general, sending remittances is the most frequent and sustained practice carried out by Mexican migrants over time. One study found that 28 percent of poor households with elderly members receive remittances (Bebczuk and Battistón 2010). The elderly parents in my study relied on them for health care. They had access to three different types: social security health care, public health services and private care. Mexican patients and their families tend to regard public health care as inefficient due to delays in receiving care, inadequate supplies of drugs and the ineffectiveness of prescribed medications and therapies. They perceive private health care as being better in quality, but not all families can afford it. A visit to a private doctor may cost 60 percent of a salaried worker's monthly wages. The only way a family can afford private medical care without incurring catastrophic expense is if they have access to remittances. The families in my study used remittance money to pay for private physicians, hospitalization and surgery, as well as purchase medicines and medical supplies. Families also used that money to save for funeral expenses and renovate the family home to suit the needs of elderly ill parents.

Local Inequalities

Although remittances increased resources for care, they also produced inequalities among families. Moises, for example, was about to lose his foot because of an ulcer that would not heal. The social security doctor had decided to amputate. Moises's family refused to accept the

"To meet their parents' needs, the migrant children engaged in four cross-border caregiving practices: financial support, care remittances, distant care and paid care."

“Medical technology sent by migrants, along with a culture of self-care, is part of this social flow.”

amputation and took him to a private doctor. After two months of treatment, the sore was healed and Moises kept his foot. All of his expenses were paid with remitted dollars. In contrast, Emiliano suffered from three chronic diseases and became paralyzed. His wife knew that if he were being treated privately, he would have a better quality of life despite his level of dependence, but this alternative was not available to him because none of his children had migrated to the United States and his family did not have the extra income from remittances.

Trade flows between sending and receiving countries are not limited to people and money, but also include “social remittances” that encompass ideas, norms, practices and identities (Levitt and Jaworsky 2007). Medical technology sent by migrants, along with a culture of self-care, is part of this social flow. Together they form a “care remittance” that facilitates the process of self-care, enabling patients to learn new practices and routines related to their illnesses. For example, when Moises, who suffers from diabetes, received a glucometer from his migrant children, the gift caused a change in his self-care behavior. Previously, he seldom knew his glucose levels and therefore could not tell if his blood sugar was under control. Once he had the glucometer, he not only knew his levels, but he and his wife learned what to do if they were too low or too high and when to see a doctor. In addition, the use of the glucometer helped his wife with her care activities, particularly in terms of food preparation and supervision of his treatments.

At the other extreme were people with diabetes who had neither migrant children nor medical technology and had to measure their blood sugar by other means. None of the children in Esther’s household had migrated, so when she suspected that her blood sugar levels were high, she tasted her urine rather than spend money on tests. If it was sweet, she deduced that her levels were high, but she did not have enough information to be able to self-manage her disease or determine when the level was a warning sign.

Patients’ relatives also benefit from access to technology, as it serves to reduce their burden of care. Juanita, for example, had two wheelchairs. She used one to move around the house, but the second, a high-quality model that her sister Blanca had sent her from the U.S., when she went outside. This meant that her 80-year-old mother could easily push her along the neighborhood streets to attend mass every week. In contrast, Angeles found it hard to push her husband’s wheelchair because of its low quality, so they only went to church every other week.

A Changing Culture of Care

Migrant children carried out other caregiving practices such as sending gifts of money, phoning their parents, and returning home for visits. Telephone calls were common among migrant children, particularly once they achieved economic stability in the U.S. During the care phase, the calls became more frequent as migrants sought to find out the parents’ health status, make arrangements to participate in specific care activities, and reaffirm their commitment to care for their parents despite the distance. On special occasions such as birthdays, Christmas, and Mother’s and Father’s Day, telephone calls were accompanied by money, a way of expressing filial love and an emotional support strategy in the repertoire of caring from a distance. Return visits back home allowed migrant children to participate more directly in caregiving practices, with the goal of resolving care issues such as visiting the doctor, making home repairs to better suit the house to the parents’ needs, and enabling all the adult children in a family to make care decisions together.

The growing number of elderly people, changes in family structure, and a lack of government services for dependents have brought changes to the culture surrounding care in Mexico. Mexicans generally frown upon the idea of having elders cared for by strangers or in a nursing home and will do all that they can to avoid it. For example, Juanita and her father Gregorio were cared for by his wife, Emilia. When Emilia died, they were left without a caregiver. Blanca, the daughter who had migrated, was unable to bring them both to the U.S. because of the immigration barrier, but she could not return to live in Mexico. So she decided to hire a female relative as caregiver.

But such arrangements are not always possible. In the private nursing home for the poor that I studied, twenty percent of the male residents had migrant children in the United States. Different factors explain why they are in the nursing home, but I will focus on the role of transnational care. The life histories of these men are similar. All of them left their families during their youth, did not fulfill their role as fathers or providers for their families, and maintained only sporadic contact with their children. In some cases, their wives and all their children had been in the U.S. since the 1990s. When these fathers become old and very sick, they returned to their children, seeking care. The children, who felt a filial obligation to care for their fathers despite the long absence, decided to take care of them. Some migrant children hired a female relative or a female neighbor as caregiver, but after several months, the growing demands of care forced them to send their father to a nursing home. Migrant children were not only paying the nursing home fees but also providing a small stipend to the caregivers for arranging their fathers’ admission to the nursing home and continuing to look after their needs.

The Transnational Parent-Care System

The caregiving practices carried out by migrant children are part of what researchers call a “parent-care system” (Carpentier and Ducharme 2003). The system consists of one or two caregivers and several helpers. The caregiver is responsible for initiating and maintaining the actual carework and performing the activities that involve face-to-face interaction, while the helpers have a “complementary task-specific” role that usually involves supplying emotional, economic and practical support to relieve some of the caregiver’s burden.

In the transnational families I observed in the first study, where the elderly person is cared for at home, a daughter or wife carries out the role of the caregiver while the rest of the children may or may not act as helpers; at least one or two usually do so. Migrant children become involved in a secure way with predictable behaviors of “caring from a distance.” In contrast, in the case of elderly men in the private nursing home observed in the second study, the parent-care system consists of a single migrant child who takes on the responsibility for distance care, sending remittances and staying informed mainly in health-related matters. Neighbors or relatives who live in Guadalajara provide minimal emotional support to the elderly men. The parent-care systems created by transnational families thus consist of a set of cross-border care arrangements with active members in both Mexico and the United States. They work as a strategy to organize and distribute responsibility for care for elderly parents among the children and ensure continuity of care in the long term.

Taken together, my two studies help explain the inequalities among elders in a sending country, and why some gain access to more economic, human and social capital than others. Global care chains may be draining care from sending to receiving countries, but at the same time they are improving care for at least one group in the former, since migrant children are in a better financial position to provide resources for their relatives than those who have not migrated. However, as long as migrants’ remittances, social as well as financial, are distributed solely along familial lines, the larger community, as well as Mexican society as a whole, will not benefit and the inequalities among elders will persist. ▮

“In the private nursing home for the poor that I studied, twenty percent of the male residents had migrant children in the United States.”

Endnotes

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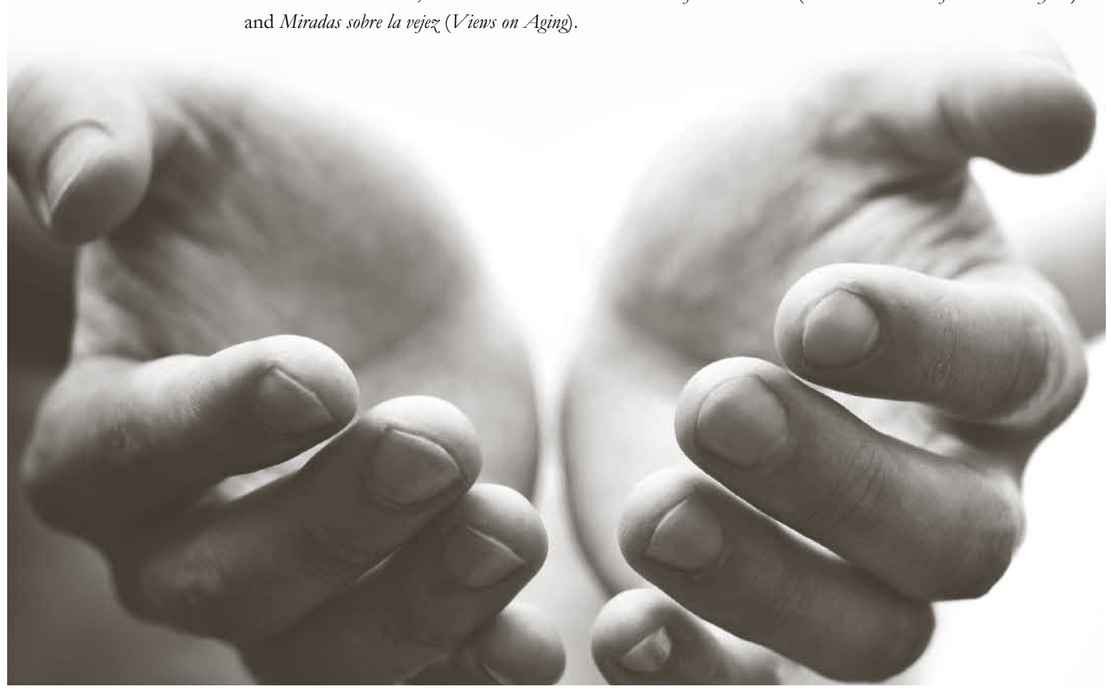

Caregivers in a Binational Context: The U.S. - Mexico Case

Xóchitl Castañeda and Magdalena Ruiz Ruelas

As long as people have been moving across national borders, societies have debated how to address the issue of immigration and citizenship. While the topic has long been enveloped in controversy and mixed views, peaks in migration within the last decade have led to growing anti-immigrant agendas and increased negative views on migration and immigrants, especially between the United States and Latin America. These sentiments overshadow the contributions of migrants and instead portray this population as a burden that simply takes from and does not give back to society. Quite the contrary, immigrants contribute substantially worldwide. In the U.S., immigrant labor keeps a large portion of the economy running. It is mainly immigrant workers who tend the fields that help feed the nation and much of the world, maintain our homes, cook and serve in the majority of restaurants, and care for our children and our elderly. Ironically, however, migrant populations face many challenges to living healthy and productive lives while working abroad.

Latinos, Mexican-born immigrants in particular, constitute a large part of the U.S. labor force, yet they are among the most socially and economically disadvantaged groups in the country. Virtually all recent immigrant men from Mexico (over 90 percent) are employed or looking for work, and hundreds of thousands of women are also working. These women do more than work in the service sector; they fulfill a number of tasks that bring stability to families. In 2006, more Mexican immigrant women worked nationally as housekeepers (310,000) than in any other occupation, and another large percentage worked as child care providers (64,000) (U.S. Census 2006). Due to the informal nature of these occupations, it is likely that these numbers are actually much higher, leaving thousands of women unrecognized for taking care of and helping to raise the next generation of Americans.

Low Wages, No Benefits

Despite their contributions and important presence in the U.S., Latino migrants—specifically the undocumented—are often seen as dispensable cheap labor and receive miniscule wages in return. The jobs they perform are among the most dangerous, pay the lowest wages and often do not provide health insurance and other benefits for workers or their families. Consequently migrants find themselves in a cycle of economic and social disadvantages. They have limited access to basic human rights, their low incomes limit their access to the very crops they grow and goods they produce, and they cannot afford to live in the kinds of homes and neighborhoods in which they garden or clean.

In terms of access to health care, Latino immigrants in the U.S. are one of the most vulnerable groups. In 2009, the uninsured rate was 32.4 percent, affecting 15.8 million people in all age groups (De Navas-Walt et al. 2009). In 2008, 16.8 percent of Latino children lacked health insurance,, a rate higher than that for white, African-American and Asian children (6.6 percent, 9.8 percent, and 9.3 percent respectively) (Pew Hispanic Center 2008); and more than one in four Latino adults lacked a regular primary health care provider (Castañeda and Ojeda 2010). Mexican-born women, who often take on caretaker roles, do not receive access to care in exchange. While they constitute the largest female immigrant group in the U.S. (five times greater than the second largest, Filipinas), over half (52.3 percent) of all adult Mexican immigrant women are not covered by health insurance—fewer than other immigrant women (Leite et al. 2010). As a result, Latinos and Latinas suffer from a number of preventable

"In terms of access to health care, Latino immigrants in the U.S. are one of the most vulnerable groups."

diseases including diabetes and obesity. They also lack proper nutrition and are typically diagnosed with cancers and other chronic diseases at more advanced stages.

Health Disparities

The health disparities among migrant populations have long been acknowledged, yet the barriers to addressing them keep growing as migration control, and with it anti-immigrant attitudes, continue to increase dramatically. Between 2005 and 2009, over 500 state laws on immigration and immigrants were passed. These laws regulate work and access to public benefits, education and security, among other rights, and also impose immigration controls. During that same period, the legislatures of 26 states passed approximately 120 bills affecting immigrants in areas linked to medical care and other public services. Their chief target was the undocumented: 80 percent of the laws related to this group were restrictive and limited their rights. Even the recently passed Patient Protection and Affordable Care Act of 2010, which is supposed to increase access to health care in the U.S., largely overlooks immigrant populations and completely disregards those who are undocumented.

> “Lawmakers concerned with immigration and health policies should take a different perspective and consider approaches that work within a more just, human rights agenda.”

Lawmakers concerned with immigration and health policies should take a different perspective and consider approaches that work within a more just, human rights agenda. In terms of immigration, policymakers at all levels should work together to find common solutions, and the public should analyze the motives behind migration. We should ask why people find it necessary to migrate, rather than strategizing about how to keep them from doing so. Immigrants are aware of the challenges and injustices they will suffer when departing their home countries, yet they are willing to endure such hardships in hopes of finding a better life for themselves and their families. The immense sacrifice and risks involved in crossing dangerous borders demonstrate that the motives to migrate go beyond simply wanting to “reap the benefits” of receiving countries. In fact, the benefits migrants receive in exchange for all they provide are far from equal. It is necessary to recognize that thousands of people continue to move across borders each day, and many more will find it necessary to do so in the future. Migrants help our nations move forward and should receive just recognition and treatment in return. ▮

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The Legal Context for Caregiver Immigration

Muzaffar Chishti

America's reluctance to respond to the need for care workers may be rooted in our belief that the United States—a new, youthful country—will always remain young. That is obviously a myth. We are fast catching up with European societies and inheriting the trappings of an aging society.

A number of facts are uncontested. Seventy-eight million baby boomers started turning 65 this year, and they are retiring at the rate of 10,000 a month. The recession may have postponed the retirement goals of some baby boomers, but not their process of aging. Demographers predict that by 2030, the U.S. population over the age of 65 will reach 72 million—that is, one in five people. The fastest growing age group in the country today is the cohort of adults over the age of 85—the group that sociologists call the "old-old." Experts have projected that by 2040, the number of elderly disabled will top twelve million.

> "...so obviously the program did not really provide an effective way to address the shortage of nurses."

A Series of Band-Aids

These facts argue for a growing need for caregivers at various professional levels. And one would assume that as a country we would have a highly developed, coherent policy to respond to this need. However, not only do we not have a coherent policy, we don't even have an *incoherent* policy. We have no policy to deal with this issue. The last time Congress considered the immigration of workers as part of the solution was in the legislation regarding nurses in the 1990s. As someone who worked on that legislation, I saw it as a classic example of a series of half-hearted, band-aid measures.

In 1989, Congress passed the Immigration Nursing Relief Act, popularly called INRA. This law gave permanent resident status to foreign nurses who had been employed in the U.S. for three or more years. It also allowed health care facilities to sponsor additional foreign nurses (called H-1As), but only if they could establish that their operations would otherwise be disrupted. That program was time-limited, and it ended in February of 1997. During that period—from 1989 to 1997—the U.S. admitted about 6,500 new nurses.

Congress expected the nurses' shortage would end in these eight years, but in 1997 the health care industry again lobbied Congress for new foreign nurses, pleading shortages. What did Congress do? Instead of extending INRA, it passed the Nursing Relief for Disadvantaged Areas Act of 1999, which allowed foreign nurses to be admitted only if they worked in certain "disadvantaged" regions of the country. These nurses (now called H-1Cs) could be employed for up to three years, but the number was capped at 500 per year. Sponsoring facilities had to certify that they were taking significant steps to recruit U.S. nurses.

That program expired in 2005. Congress, again in response to industry lobbying, extended it, and the program finally ended in December of 2009. That year, the U.S. admitted only 126 foreign nurses, so obviously the program did not really provide an effective way to address the shortage of nurses. At the same time, the country lacked a robust workforce development program to attract more native-born workers into the nursing profession; we neither increased training opportunities nor improved wages and working conditions.

Openings for Migrants under Current Law

In the absence of any other special, tailored categories of visas to meet the demand for caregivers, employers who need access to these workers have had to rely on the options in our general immigration law. Let me quickly lay them out.

Our immigration selection system provides for two streams of employment-based immigration: permanent and temporary. In the permanent stream, we have three broad categories. The first two are reserved for select, high-end professionals and are thus mostly irrelevant to this discussion. The third is what we call the EB-3 category. This includes professionals with a bachelor's degree and those with skills that require at least two years of experience. It also includes a sub-category of "other" workers—by definition occupations requiring less than two years' experience. Most caregivers fall into this EB-3 category.

Only 140,000 visas per year are available for *all* employment-based immigration categories—and that includes both the principal worker and his/her dependent family members. The EB-3 category is allotted 28 percent of these visas, only 5000 of which may be given to those in the "other," lesser-skilled category. And then we have per- country limits for each category. The combination of these rules creates a huge–and growing—backlog for admission of these workers. Currently, for workers from Mexico or the Philippines, the wait is eight years; from China or India, even longer. Can any employer plan realistically for workers who will arrive eight years down the line?

The situation is similar for the temporary worker stream. We have only limited categories of temporary worker programs. H-1B visas are reserved for professionals—those who have at least a bachelor's degree. Some nurses can qualify under the program, but most do not. Thus for most potential caregivers, this category is not a real option.

We also have a category called H-2B, which applies to temporary workers in non-agricultural occupations. Sixty-six thousand visas per year, covering all occupations, are available for workers in that category, but they come with two significant requirements. The job, by its very nature, must be temporary, and employer's need for the foreign worker must be temporary. This is what we call the "two-pronged temporariness" in the H-2B programs. Case law in this area suggests that to meet H-2B requirements, an employer must prove that the need for the worker is short-term, seasonal or intermittent. Very few occupations in the caregiver field fit these criteria, so, once again, this is not really a meaningful option.

Thus the legal avenues for migrants who could meet the demand for caregivers are obviously very limited. Nevertheless, as in many other U.S. occupations, foreign workers constitute a sizable proportion of the labor force. About 25 percent of our physicians and surgeons, 14 percent of our registered nurses, 24 percent of psychiatric home care aides, and 13 percent of other health care support workers are foreign-born.

Some of these workers are admitted lawfully on employment or family-based visas, but for many, especially among the low-skilled, the absence of legal avenues forces them to use illegal channels to immigrate. And to many observers, that is the definition of our broken immigration system.

Special Problems for Caregivers

The plight of caregivers presents at least two other problems. First, the unauthorized among them are vulnerable and understandably scared to complain about violations of their labor rights. Second, many of the caregiving occupations in which migrants work are actually exempt from important statutory labor protections. As a result, their wages and working conditions have consistently declined.

The one bit of recent good news in this regard is that U.S. domestic workers are beginning to organize. Last year New York State became the first in the country to pass a domestic workers' bill of rights. Domestic work is now recognized as a distinct occupational category and workers in this field are entitled to receive a standardized work schedule from their employers, as well as overtime protection and three days off every year. While clearly modest,

> "About 25 percent of our physicians and surgeons, 14 percent of our registered nurses, 24 percent of psychiatric home care aides and 13 percent of other health care support workers are foreign-born."

this bill still represents a major historic step in recognizing the rights of this group of workers. Support for similar legislation is growing in other parts of the country, most notably, California.

Given all of this, it is evident that only a major revision of our immigration law and selection system can address the need—and provide the labor protection—for caregivers and those in similar occupations. This takes us to the discussion of what is popularly called "comprehensive immigration reform." There are many elements to this reform package, but let me focus on only one that is relevant to this discussion: how do we increase the number of immigrants admitted to the United States on the basis of labor-market need?

> "Most analysts agree on the need to increase the number of workers admitted on employment-based visas...."

Most analysts agree on the need to increase the number of workers admitted on employment-based visas, but there is disagreement about whether they should be admitted as temporary or as permanent immigrants. Given the history of temporary worker programs, this question provokes heated controversy.

A Possible Solution

We at the Migration Policy Institute (MPI) have proposed the creation of a new category of employment-based workers called "provisional workers." This would be a hybrid between a pure temporary worker and a permanent visa category, covering a broad set of occupations. Workers would be sponsored by an employer, pursuant to certification that their employment would not adversely affect U.S. workers. To cut the red tape, employers with consistent record of complying with immigration and labor laws would be pre-certified. Provisional workers would have the option of changing employers within their occupation, and they would have all the labor rights and protections of comparable U.S. workers.

Provisional workers could be admitted for a period up to three years, after which they would have the option of returning to their home countries or extending their stay in the U.S. by another three years. At the end of six years, provisional workers could choose to return to their country and potentially re-immigrate as provisional workers after a few years. This option would encourage a kind of circular migration. As a further incentive, provisional workers would get credit for their social security contributions in the United States through mutual agreements negotiated between the U.S. and their home countries. Those who chose to remain in the U.S. would have the option of transitioning into permanent resident status.

The number of workers admitted each year as provisional worker would be flexible, not frozen into statute as in our current system. MPI has recommended the creation of an independent standing commission of experts that would recommend on a yearly or bi-annual basis the number of provisional workers to be admitted. That number would be based on factors such as our labor-market needs, our ability to educate and train U.S. workers to meet those needs, demographic trends and projections for economic growth.

Many of these are not novel ideas; indeed, elements of them have been around for many years. The immigration debate no longer suffers from lack of ideas. What is lacking is the political will and the political space to turn these ideas

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A Temporary Care Work Program for the United States? The Political Context

Margie McHugh

We can put any number of ideas on the table for how to establish new temporary immigrant worker flows, but we must also have a hard-headed conversation about what, realistically, can be done in the short term. In what follows, I walk through a basic outline of the current immigration debate in the United States, explain why we are stuck politically, and discuss prospects for action on immigration reforms pre-election and post-election. I will end with an out-of-the-box idea for how we might move forward.

The Comprehensive Approach

For quite a while, "comprehensive immigration reform" has been the buzzword in the American debate. And this invariably leads to the question, is it better to push for comprehensive reform measures or for what we call piecemeal legislation? (Temporary migrant care worker programs might be thought of as a type of piecemeal legislation.) The idea that comprehensive reform is needed arises from the large population of unauthorized migrants in the country—some eleven to twelve million—who constitute a central sticking point in any discussion of immigration measures.

How did that population develop? There are a number of explanatory factors. One is the point Muzaffar Chishti discusses, namely the country's low cap on unskilled workers—only 5,000 visas per year. Obviously that is too low for a country with the size and economy of the U.S. Another is the per-country limit of seven percent of the annual total of immigrants. In some cases demand in excess of these limits has created backlogs of family members who have been approved for residency but cannot enter the country until a visa becomes available—sometimes decades in the future. When people are in the family visa waiting period or backlog, they know that their petitions for residency have already been approved—in other words, that they have a legal basis upon which to immigrate. Many then equate this with already having legal status but thinking it's just that they won't get their "formal" papers for a while. It is easy to see how this translates into unauthorized migration.

A third factor is gaps in enforcement. This is a complex question, comprising border, interior and workplace sites, the laws and practices governing which have not been sufficient to prevent millions of unauthorized immigrants from entering, settling and working in the United States. Then there are the several million people who probably should have been included in the last legalization program, in 1986, but were left out because of the way it was structured. This bred more illegality, which in turn has fed the numbers we have today. And finally, the booming economy of the last ten or fifteen years, with very low unemployment, created a jobs magnet beckoning thousands of workers to the U.S.

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These things may seem obvious, but it is important to mention them because invariably discussions of comprehensive immigration reform assume that any solution must address every one of them since they are all interrelated. Most political pundits doubt whether the U.S. government is able to do anything comprehensive anymore (attempts to pass comprehensive health care reform legislation being the most recent case in point), and suggest that we must simply accept the idea that, given our form of government, this is a period in which only piecemeal fixes are possible, no matter how big and complex the problem. Yet many cling to the idea that comprehensive immigration reform must be legislated.

One component of such a bill would be enforcement, with policymakers debating what form it should take. Proposals include strengthening the E-verify system (in which many U.S. employers already participate), sending more money and investment to the borders and

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expanding interior regulation by using more state and local entities to enforce federal immigration law.

A second major component would be a broad legalization program. Some propose a forward-looking policy that would take the form of earned legalization. Individuals would apply, have a temporary period of residency, meet a number of different standards and eventually move onto a path toward citizenship. It this last aspect that is the most controversial, pitting conservative lawmakers against advocates of immigrant communities, who hold firmly to it.

A third component of the comprehensive approach would entail clearing out the family backlog—the several million people who are already approved for immigration but compelled to wait their turn to enter. Many contrast these people, who did not break the law, with the eleven to twelve million unauthorized immigrants. It may be that many of the individuals in the backlogs are in fact already in the country and make up part of those millions. Nevertheless, the idea that people who are unauthorized should not be allowed to "jump the line" in front of people who have visas pending figures prominently in thinking about a comprehensive bill.

Another component is the future flow. The previous legalization program has been criticized for putting the country back into the same situation, requiring yet another legalization program. Some lawmakers say the only way to avoid this is to seal the border and institute harsh enforcement provisions. But others contend that because we have such a narrow pathway for legal immigration, it is important to address the question of future flow directly and get it right this time. We need a system that can realistically meet the country's needs and manage the supply-and-demand issues, for labor in particular, that form the basis for the current situation.

Finally, there is the issue of immigrant integration. All too often this is addressed from a negative perspective, involving provisions that would prevent those who come in under a legalization program from accessing social benefits, establishing requirements that legalizing immigrants learn English and stipulating under what terms those legalizing can become U.S. citizens. Decades of inattention to a broad range of immigrant integration needs are, in fact, driving popular opposition to more generous immigration policies.

Why We Are Stuck

When it comes to immigration reform, lawmakers find themselves deeply at odds, with one side calling for a generous legalization component which the other abhors, and the other side saying it must have robust new enforcement measures, which those seeking legalization reject. There is also a somewhat less heated disagreement around the questions of future flow. Here the conversations are difficult but fairly nuanced, and it is fair to say that the two sides have found more room for negotiation.

Meanwhile, in the background is a more general disagreement on the need for, or the value of, having generous immigration policies at all. What role should immigration play in our modern economy, in our modern society? There is no place in the national conversation for considering such foundational concerns because the debate has been structured around two rigid off-the-shelf policy approaches or products: immigration is all good or its all bad. Because the debate is so polarized, there is no opportunity to sort out solutions that address the concerns represented by the two ends of the spectrum, and progress is curtailed.

Piecemeal bills offer one way to move forward. Over the past decade, such bills have always had their supporters, though they were generally disfavored by the broader advocacy community, precisely because they did not address a wide spectrum of reforms. The dynamics around piecemeal reform have been particularly difficult for advocates to manage this past year, given the intense pressure for a legalization program from immigrant and Latino communities that are feeling the effects of increased enforcement efforts. The two most prominent of the piecemeal bills are the DREAM Act, which would, under certain conditions, grant permanent residency to individuals who arrived in the country illegally as minors, and AgJOBS, a bill that would address particular needs in the agriculture industry. In addition, there have been various bills to address the need for highly skilled immigrants.

Many advocates and policymakers who support a broad legalization program have been reluctant to move on piecemeal legislation because they believe that it forecloses possibilities for making comprehensive gains in the future. The immigrant rights movement debated supporting the DREAM Act, for example, out of fear that if roughly two million young people—arguably the most attractive of the eleven to twelve million undocumented—were given a path to legal status, the plight of the remainder would be ignored. Advocates were also, rightly, concerned that very big concessions would be required to secure passage of the bill, particularly with regard to new enforcement provisions. They would be willing to make such concessions only in return for a full, broad legalization program that includes most of the unauthorized.

Finally, many advocates believe that gathering sufficient support to pass a piecemeal bill takes as much effort as for comprehensive immigration reform. Because party and political lines are so strictly drawn, vote counts come up short in both the piecemeal and the comprehensive scenarios, so why even try to move a lesser bill? In fact, the negotiations and vote on the DREAM Act demonstrated that it is probably easier to move on some of the piecemeal bills than on comprehensive reform, but this belief persists.

It is true that, because of the Senate's rules, sixty votes, not a simple majority, are needed to advance any bill, and immigration reform has not been able to attract a super-majority for some time. After the last presidential election, with the Democrats in control of both houses, it was assumed that the issue had sufficient momentum to get a comprehensive bill through, but it soon became apparent that on a vote related to broad legalization measures, eight or nine Democrats would peel away from the party's narrow majority, so a dozen or more Republicans would be needed to pass a comprehensive bill. But Senator Charles Schumer (D-New York) could not even get one Republican partner to introduce a bill with him. So not only were advocates no closer, as many thought they would be after the election; they were really in a deep hole when it came to getting enough votes for passage.

Many pinned their hopes on the rising power of the Latino vote to change the politics of immigration, but in fact Latino voters matter mainly in the presidential election, less so in most state elections such as those for senators. In national elections, they may help tip one of the swing states into the Democratic column, but in most states their power is counteracted by that of independent voters, who are more numerous—and generally more conservative.

It is also important to point out the dynamics of reward and punishment around the immigration issue. Current policy debates reveal the effects of hyper-politicization—the framing of every detail of an issue in terms of the ideological war between the two parties. This dynamic makes it difficult to get to a majority in favor of action on immigration reform. If a dozen or more Republican votes are needed to move some sort of immigration reform, how does one create a package to appeal to them? It is the voters at the ends of the political spectrum who are most motivated on this issue; those in the middle don't necessarily vote on it because they don't care that much about it or consider it equal to other issues. From the perspective of a senator or representative, a move to the middle on immigration brings only misery and pain from the more highly motivated ends of the electorate—punishment from opponents, no reward from supporters for compromise. So, because of the extreme polarization of our larger politics and the insistence on sweeping or comprehensive immigration reform measures, we are truly stuck with trying to move on these issues.

Prospects for Change

The upcoming presidential election may offer an opening for passage of some form of immigration reform. Many contend that the Republicans would have difficulty at the polls without doing something that shows real consideration for Latino voters by actually giving them something on an issue that matters to them. With this in view, the DREAM Act was re-introduced this past May. Some believe that other piecemeal bills might be possible before or soon after the 2012 elections, for example those addressing issues such as highly skilled workers or other discrete labor needs. Family visa backlogs are also high on the list, on the assumption that if lawmakers were inclined to compromise, it would

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make sense to accommodate those who have a legal right to immigrate and are just waiting for the clock to tick through so that they can collect their visas.

In addition to the two reforms that Muzaffar Chishti mentioned from the Migration Policy Institute's work several years ago—creating a standing commission on immigration and labor markets and establishing provisional visas to help meet labor force needs—I would like to suggest one more out-of-the-box idea, one that is similar to the Canadian provincial selection system. Emerging from conversations within the coalition that Mayor Michael Bloomberg of New York has put together to look at immigration reform issues, this would entail developing a pilot program that sets up shared authority for immigrant selection between states and the federal government. Such a program could address specific labor force needs, like that for care workers. Many American states might be eager to prioritize entry for these workers under a partnership with the federal government.

A pilot program could test approaches to meeting different types of needs, such as population decline or worker shortages. States and counties currently facing critical deficits of younger residents might want to consider ways to enhance their regions' attractiveness to newcomers, including immigrants. In New York State for example, the demand for particular kinds of workers led government leaders in the western part of the state to run weekend bus tours of their cities to show immigrants living in New York City neighborhoods the improved housing and quality of life they could have if they moved upstate and agreed to take the jobs available there.

Programs sparked by the Workforce Investment Act of 1998 may provide models for new immigration policies. In the wake of this legislation, many states have made significant progress in aligning their post-secondary education, workforce and economic development services and programs with the needs of employers. To be more responsive and integrative, these states now routinely produce sophisticated analyses of their demographics, industry outputs, occupation projections and the like to guide their education and workforce development efforts.

At least one state has already begun to link these policies with immigration. Although Washington has made considerable efforts to solve educational and skill needs in dozens of occupations through workforce and economic development planning and industry partnerships, the state is still facing shortages in critical occupations, such as dentistry. As a result, Washington's policymakers called for federal legislation to bring in immigrant dentists. This sort of sophisticated planning at the state and local levels should be given a chance to drive federal migrant selection policies.

Any pilot selection program should incorporate in its design measures to address key worker rights, such as those covered in the Domestic Workers Bill of Rights recently passed in New York State. States competing for visas could earn extra points if they demonstrated rigorous enforcement of wage and other workplace protections in the occupations in which they were seeking to bring in more workers. Given the logjam the U.S. faces in moving forward with conventional immigration reform legislation, it seems that circumstances may be converging to make targeted temporary flows, perhaps within the rubric sketched out here, a more attractive and practical approach to solving pressing workforce needs while ensuring that the rights of such workers are effectively protected. ▮

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