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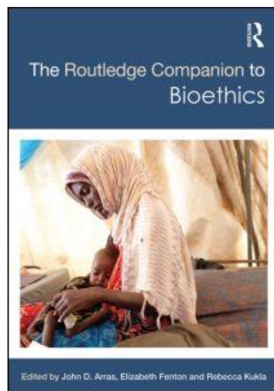

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Family Caregivers, Long-Term Care, and Global Justice

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FAMILY CAREGIVERS, LONG-TERM CARE, AND GLOBAL JUSTICE

Lisa Eckenwiler

One important explanation for the flow of health care workers across national borders is the growing demand and expectation in affluent countries, including Western welfare states, for affordable, quality long-term care services (OECD 2005: 10). This is one part of a global trend. Foreign-trained health care workers are increasingly likely to move from low-income countries with an inadequate number of care workers and high disease burdens to more prosperous and healthy parts of the world, especially North America, Western Europe, and the high-income countries in the Gulf and the Western Pacific (Polsky *et al.* 2007). This migration is skewing the distribution of the global health workforce and deepening health inequities, creating a global "crisis in health" (WHO 2006).

The most pressing question is what is owed to countries confronting health worker shortages and high disease burdens, particularly countries from which these care workers (and for that matter all nurses, physicians, pharmacists, etc.) migrate, after having been in many cases actively recruited. Still other crucial matters concern what is owed, by whom and why, to migrant care workers. We might consider governments in both destination and source countries, employers such as health care systems and institutions, and profit-making recruiters as primary moral agents here. And indeed, the responsibilities of some of these agents have been identified and enumerated in bi-lateral agreements, codes, guidelines, conventions, and other international instruments. These ethical interventions aim mostly at protecting health systems of source countries by enumerating principles for managing migration, but they also condemn deception and misrepresentation in recruitment practices, and call for employers and governments to treat migrant care workers with respect and to provide them with labor protections equal to those of citizens (Academy Health 2008; Commonwealth Health Ministers 2003; U.K. Department of Health 2004).

In this essay, I shall focus on the special moral agency of families in destination countries, and consider what they might owe care workers upon whom they rely to support their dependent, elderly family members in home and institutional care settings. Family caregivers are situated together with migrant care workers at the epicenter of shifting economic and care regimes, and find themselves forging cross-border relations as they

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care for and/or about elders in affluent countries. While most interventions aimed at addressing injustices in migrant health worker recruitment, migration, and employment have taken the shape of political-legal-institutional responses and calls for reform, I investigate the potential of practices (Kurasawa 2007), or particular forms of moral engagement, by family caregivers to advance the work of global justice.

I begin by describing the influx of migrant care workers into the U.S. long-term care labor sector. In this section I also identify and chart the ethical implications of a host of factors that compel care workers in low-income countries to cross borders for their own benefit and that of their families. Next I situate family caregivers within their social, economic, and political context and describe their plight as they try to care for loved ones while contributing to injustice in relying on workers from abroad. I show how both groups manage amidst structural injustice given their respective social and economic circumstances, and explain why family caregivers might have responsibilities to these workers, emphasizing their contribution to the identities of the dependent elderly and their loved ones, and even to the broader culture of destination countries. In the last section, I examine the potential for three practices of what I call "privileged responsibility"—recognition, solidarity, and preventive foresight—to advance the work of justice. Even as structural injustice persists in the transnational organization of long-term care and global health inequities fester (Eckenwiler 2012), my hope is to carve out a space for small steps that ordinary people might take, engaging their moral agency to mitigate moral damage and perhaps, even, promote justice for migrant care workers and people in source countries facing shortages.

Migrant Long-Term Care Workers in the U.S.

Long a low-wage, female, and so-called "minority" industry, long-term care has also become a transnational endeavor (Browne and Braun 2008). In the U.S., as in other privileged countries, a growing number of migrant care workers—mostly women—now find employment in the long-term care sector. An estimated 30 percent of foreign-educated registered nurses (RNs) work in long-term care, and approximately 48 percent of RNs working in home care specifically come from abroad (Martin et al. 2009). Among foreign-educated licensed practical nurses (LPNs), as many as 80 percent are employed in long-term care. A similar trend can be seen among direct care workers like nurses' aides and home health workers, the frontline of the paid long-term care workforce. Approximately 20 percent of direct care workers are born outside the U.S., most of them in low-income countries (Paraprofessional Health Institute 2011). Among home health aides, the foreign born and educated make up an estimated 24 percent. Although the data are difficult to come by, the top countries of origin for these workers are the Philippines, Jamaica, Haiti, India, Nigeria, and Ghana (Martin et al. 2009).

Demand for home health aides is rising especially quickly with the demographic shift toward a more elderly population and as the impacts of budget constraints unfold. Cuts to health and social service programs work partly by shifting from public to privatized service provision—most often provided at home and sometimes with cash transfers—that enable the elderly to purchase services "independently." These structural shifts are significant given that by 2040 the number of older adults using paid home care is expected to increase by three-quarters (Johnson et al. 2006). Home health and personal care aides have been identified as being among the fastest-growing occupational groups (U.S. Bureau of Labor Statistics 2007). Many of these workers are migrants.

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Several factors align to facilitate the unprecedented flow of care workers across borders. Colonialism and longstanding interdependent relationships (Raghuram 2009: 30) have contributed to transnational health worker production and exchange. U.S. missionary and military involvement in the Philippines, along with targeted foreign policy strategies, began fueling the mobility of Filipino nurses over a century ago (Choy 2003). Similarly, the modern-day migration of Indian nurses can trace its roots back to the British Empire's Colonial Nursing Association (Rafferty 2005).

More recently, the re-structuring by international financial institutions of economies and public institutions in low and middle-income countries has generated job losses in many sectors, including health care. At the same time, some of these countries have come to organize their economies around the training and export of human resources, with the hope that remittances will help to reduce the burden of debt and poverty. In addition, efforts are underway to craft global trade policies (specifically the Global Agreement on Trade in Services, or GATS) to allow for the commodification and trading of care services on the global market (Connell 2010).

Selective immigration, especially for skilled workers in areas facing shortages, is an essential instrument of industrial policy under globalization (Ahmad 2005). Health and long-term care industry organizations in high-income countries, who regard international recruitment as a way to address shortages and reduce hiring costs and improve retention, often lobby to ease immigration requirements in order to gain access to nurses and other care workers (Buchan et al. 2003). A for-profit recruitment industry that services health care corporations has blossomed in this environment (Pittman et al. 2007).

Meanwhile, extremely poor working conditions and inadequate planning for demographic shifts in well-off countries have resulted in long-term care workforce shortages (Institute of Medicine 2008). A recent report argues that the unprecedented reliance on migrant care workers around the world is a symptom of the lack of comprehensive long-term care policy (International Organization for Migration 2010: 7). More generally, countries' "care regimes" can contribute to the flow of migrant workers. How governments structure provisions for the care of children, the ill and the elderly, including support for family caregivers, has implications for the demand for migrant workers. In countries with strong welfare states and provisions for care of the dependent, there appears to be less demand for such workers than in countries with weak welfare states (Michel 2010). I will say more on this below.

Transnational Identities, Autonomy, and Equity

What are the implications for migrant care workers' autonomy and prospects for equity? If we understand autonomy to mean something like being relatively free to choose one's actions and course in life from a decent set of options within a complex set of relations—familial, social, and economic—and equity to mean something like the absence of avoidable and unfair inequalities, the picture that emerges is complex.

Long-term care harbors some of the worst working conditions found anywhere. The people who are working in long-term care are frequently devalued, not treated with respect, and paid extremely low wages (Paraprofessional Health Institute 2010). These workers report high rates of job stress and low satisfaction, even when they say that they believe in the importance of their work (Castle et al. 2007). Direct care workers tend to fare the worst. Using the U.S. Census definition, approximately 15 percent are poor; two out of every five rely on public benefits such as food stamps and Medicaid. Many of

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them, especially home health aides, also lack benefits, including health insurance and sick leave. Nearly 30 percent go without health insurance. Perversely, however, nurses' aides and home health workers have higher than average rates of diabetes, asthma, and other chronic conditions, and have one of the highest rates of job-related injury among all occupations (U.S. Bureau of Labor Statistics 2009). They also often lack retirement benefits, which can, over time, place them in economically perilous conditions (Paraprofessional Health Institute 2011).

Threats to autonomy and equity for migrant care workers, in particular, come from several other sources. Women seeking employment in more affluent countries as maids, nannies, and nurses are now an integral part of the global and increasingly service-oriented economy (Dumont et al. 2007). Yet to the extent that their migration is fueled by gender norms and racial and cultural stereotypes that help to organize who does what work, and assign reduced meaning and value to various forms of work (Brush and Vasupuram 2006), it raises ethical concerns. At the same time would-be migrants from low- and middle-income countries are situated amidst nationalist rhetoric that supports neoliberal economic policies and encourages migration. One form encourages workers to organize their conduct around what is beneficial to states' economies (Ilcan et al. 2007). Another variety emphasizes "the active citizen," who allegedly maximizes quality of life by being not just a consumer, but also a participant in the global labor market (Schild 2007: 181). When it comes to migrant care workers, Filipinas, for example, are frequently stereotyped as caring, obedient, meticulous workers, or as "sacrificing heroines" (Schwenken 2008). These rhetorical strategies operate with a caring face, suggesting that labor migrants, especially women, will enjoy expanded opportunities for choice and prospects for equality. Yet by helping to create and nurture subjectivities that align with economic structures and modes of organizing labor, that, among other things, here serve to sustain restrictive gender roles and enforce expectations for individual (as opposed to social) responsibility for familial and national wellbeing, they constrain imaginations and opportunities for women and girls.

Most migrant laborers are subject to "flexibilization," Nancy Fraser's term for a "process of self-constitution that correlates with, arises, from, and resembles a mode of social organization" (Fraser 2009: 129). Its central features, on her account, are fluidity, provisionality, and a short-term temporal horizon. Transnational economic and other structures compel care workers to mobilize, when most say they would rather work in their home countries. Movement to care-related labor markets in the North may involve taking jobs below the education and skill level of care workers, a practice known as "down-skilling." There is also the rapid expansion of the "gray" economy, and the tendency under neoliberal economic policies to define more and more jobs as temporary and unskilled. Inequities may persist under such schemes, and choices may be constrained. Furthermore, although countries often incentivize immigration for some workers, they differentially incorporate migrants when it comes to immigration and citizenship status (Carens 2008). Care workers, especially the allegedly "unskilled," often lack citizenship in the countries where they are employed, and therefore, have a limited set of political rights and, even more than other long-term care workers, limited labor protections and access to health and social services (Bosniak 2009). Recent studies have found that the differential granting of rights to migrants through immigration policies has significant implications for the kinds of work they get, their "exit powers," and "voice" concerning their working conditions, and for their abilities to meet their goals (Shutes 2012).

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More generally, like other migrants who describe feelings of dislocation, many nurses working abroad report a sense of "having a foot here, a foot there, and a foot nowhere" (DiCicco-Bloom 2004: 28). Many live in transnational families (Baldock 2000). To the extent that people are shaped by familial relationships and engagement in the communities and places from which we come, migration leads not just to a geographic but a "self-rupture" in many instances (Kittay unpublished). Indeed, these care workers, according to Kittay, experience a sort of "bi-placement" of identity, that is, of "never feeling oneself as fully here." These moral harms faced by individuals can at the same time threaten the relationships themselves; they may lead to the thinning of bonds, and the reinterpretation of status and standing (Miller 2009: 513).

Evidence suggests that migration can have adverse effects on health (Migrant Clinicians' Network). Undocumented, non-citizen care workers are especially vulnerable. They generally cannot seek work in institutional settings that offer employer-sponsored health insurance. While many care workers who are U.S. citizens do not have health insurance as part of their employment package, they might qualify for Medicaid. In contrast, all undocumented non-citizens were rendered ineligible for Medicaid by the 1996 *Illegal Immigration Reform and Immigrant Responsibility Act*. That group is also not positioned to purchase health insurance because its members do not have social security numbers or sufficient financial resources. Moreover, fears of deportation deter them from seeking care in public health clinics or emergency rooms. In short, although undocumented care workers are increasingly essential to social welfare in destination countries, they are often excluded from their benefits (Meghani and Eckenwiler 2009).

Migrant care workers can, of course, reap significant benefits by working abroad. There can be important gains for women in areas like self-trust and confidence, household decision-making and expenditures, as well as in spatial mobility and freedom from restrictive gender norms (McKay 2004). They may advance their respective migration projects, that is, achieve goals they have set for themselves, albeit under constrained conditions, whether this means contributing to wellbeing for their families and themselves at home, or ultimately gaining traction and stability in destination countries. Depending upon a range of factors, many care workers may well be vulnerable, yet become more autonomous and gain greater opportunity (Straehle 2013). Granting this potential, it nevertheless seems reasonable to conclude that migrants' overall prospects for autonomy and equality are at the very best highly uncertain (Abraham 2004).

Situating Families

The work of family caregivers—the vast majority of whom are women—is integral to the global health workforce. Around the world, family members are the primary providers of care, including long-term care for the elderly. At least 30 percent of adults in the U.S. are family caregivers, offering on average 200 hours of support per month, serving as a source of emotional support, coordinating care, accompanying the elderly to medical appointments, managing finances, and often delivering medical care (National Alliance for Caregiving and AARP 2009).

In spite of its integral contribution to social organization and cooperation, the care provided within families has long lacked social standing and respect in many places. Care labor is not typically seen as work, or in economic terms, as productive. Yet those who have tried to attach a dollar figure suggest that in the U.S. alone, the estimated

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worth of the long-term care work done by family members is somewhere over $375 billion and on the rise (AARP 2008).

The changing circumstances facing families in many affluent countries add to the challenges of ensuring adequate long-term care for elders in need of assistance. Families are having fewer children and are increasingly likely to be dispersed geographically. Meanwhile, opportunities for women in the paid labor force have expanded. In a shift from earlier eras, the majority of family caregivers in the U.S. and other high-income countries are employed in the paid labor force. The support of households, even in wealthy countries, increasingly demands the wages of two earners. This represents a departure from one of the pillars of the traditional, nationalist welfare state, the gendered division of labor involving male breadwinners and female homemakers.

At the same time, however, as many governments restructure to spend less on health and social needs, and health care institutions cut costs, a "care gap" has emerged that ultimately relies upon family caregivers to contribute additional energy and resources. Arguing on the basis of cost-effectiveness and consumer self-determination, choice, and benefit, many governments have begun to restructure their role in the provision of care and welfare services—especially home care and personal care assistance—and moved toward greater privatization and informalization (Shutes 2012). At the same time persistent efforts to cut health care costs have included shortened stays in hospital settings and early discharge of patients. These economic strategies have shifted responsibilities onto family members (Christopherson 2006).

In this context, U.S. employers offer little support. While this phenomenon holds true in many other countries, the U.S. has been described as having "the most family-hostile public policy in the developed world" (Williams and Boushey 2010: 1). Given the rigidity of many contemporary work schedules, family caregivers must conform and make do. Those in the paid labor force typically find themselves distracted, distressed, able to work fewer hours than they did before, and taking unpaid leaves. They often pass up opportunities for advancement. The reduction in work hours that some find necessary tends to translate into a loss of economic and other benefits. Finally, a growing body of research finds that family caregivers are at heightened risk for chronic, elevated stress and depression, poor physical health, and death (Godfrey and Warshaw 2009).

In all, family caregivers manage in the face of serious inequalities and constraints. Embedded in family ties and entangled within social and economic norms and institutional policies that are deficient from the perspective of care, the loved ones of the elderly who can do so increasingly rely on migrant workers to play a supporting role.

Injustice and Responsibility

The threats to autonomy and equity confronting family members and migrants amount to structural injustice. Structural injustice exists when social norms and economic structures and other social processes systematically thwart some people's prospects for self-development and self-determination as they simultaneously expand the prospects of others (Young 2006: 114). The examination above of the plight of family caregivers and migrant care workers reveals the extent to which both are situated amid social norms and economic structures, institutional rules, and patterns of interaction which expand opportunities for the well-to-do and contract them for the less well off.

When it comes to our focus here, relationships between family caregivers and migrants, there are glaring asymmetries in their experience of structural injustice. Family

caregivers in the North indisputably struggle to varied degrees, depending upon their social and economic position. Yet they are far better situated than care workers who have migrated, given their elevated global economic position, wider range of options, and greater purchasing power. Indeed, the dense and radically asymmetrical relations of interdependence connecting them to migrant workers in long-term care ground responsibilities for family caregivers. There are several ways to think about this interdependence.

In the broadest terms, we might consider obligations of global justice as being grounded in our shared humanity. On a view that attempts to account for more specificity in our relationships, an agent's moral obligations encompass all those people upon whom her own activities depend, including the geographically distant (O'Neill 2000). Another view holds that we are related through shaping and sustaining the institutions and processes that generate global poverty, and that, in turn, helps to motivate migration (Pogge 2005: 33). Closely related is the "social connection model of responsibility" in which contributions to the structural processes that produce injustice generate responsibilities to remedy them (Young 2006: 103).

As citizens of a democracy, family caregivers elect leaders who help to establish the health, labor, and immigration policies that help mobilize care workers from poor countries. These same citizens support leaders who create and perpetuate the policies of international financial institutions, such as the World Bank and the International Monetary Fund (IMF) and trade organizations like the World Trade Organization. Then too, there are the demands and expectations of privileged people concerning long-term care. When it comes to family caregiving, these demands and expectations rest in part on certain social norms families support regarding care. As Joan Tronto points out, the pervasive tendency, particularly among white middle and upper class families, to understand caring as a matter involving the needs of their loved ones, and to act exclusively according to what appears to be best for them, can lead to moral hazards. In understanding caring in such private terms—as families are socially and economically compelled to do in the U.S.—they may not consider the implications for those who support them or for their kith and kin in less well-off parts of the world. Such myopia constitutes, in Tronto's (2006) words, "privileged irresponsibility."

Reflection on the relationships between source and destination countries, and between migrant and family caregivers, invites consideration of another way of thinking about grounding responsibilities. Specifically, the global interdependence that increasingly characterizes care work reveals the relational nature of our identities. Underpinning the relational conceptions of justice described above are relational conceptions of persons (and also of places). In other words, identities are established and maintained inter-subjectively, through dependency relations and interactions with family members, friends, and other social relationships. The care provided by migrant workers—nannies, nurses, home care aides, and others—has long been and now is an increasingly integral part of the identities of those who benefit from it. It sustains individuals who are beneficiaries of care and members of their families, expanding their opportunities by enabling them to have expanded access to health care services, or even having a walk around or eating regularly. Family caregivers might gain, for example, more time with their children, the chance for evening walks, or hours to work on valued projects. The presence of migrant care workers seems also, in a general sense, to shape the identities of citizens of an affluent country as participants in and beneficiaries of economic and labor policies that rely on low wage workers. We are responsible for addressing injustices such workers suffer, then, not (merely) because of

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our participation in processes that generate injustice, but also because of their intimate and crucial contribution—given under some measure of constraint—to who we are (Eckenwiler 2012). The scope of this argument expands to relationships even between people unknown to one another. It holds special force when there are particular, intimate relations involving migrants and families.

It is important to add here that adverse effects—whether to migrants, their families, or their countries' health systems—are not necessarily intended. Indeed, structural injustice often occurs as a result of our (individual and institutional) choices and actions as we try to advance our own interests, typically within accepted rules and parameters (Young 2006: 114). Despite the absence of any intention to harm, and despite the constraints they too confront, family caregivers in destination countries have special obligations to the migrant care workers upon whom they rely.

So what, then, might constitute privileged *responsibility*?

Practices of Privileged Responsibility

Governments, along with networking institutions like the World Health Organization have crafted instruments aimed at responding to injustices against transnational health care workers and source countries. According to Fuyuki Kurasawa (2007: 6), however, understanding global justice as emerging principally through prescriptive or legislative means overlooks "the social labour and modes of practice that supply the ethical and political soil within which the norms, institutions and procedures of global justice are rooted." It is important, in other words, to imagine the potential of personal interactions and practices to advance justice.

Kurasawa identifies five practices that advance the work of global justice: Bearing witness, forgiveness, giving aid, solidarity, and preventive foresight. Such practices may accompany or in some cases facilitate political, legal, economic, and institutional reform aimed at global justice. I consider three practices through which family members who rely upon migrant care workers, whether for home-based or institutional care, might contribute to the expansion of autonomy and equality for migrant care workers: Recognition, solidarity, and preventive foresight.

Recognition

Researchers have examined the ways that people, in profoundly intimate relations of care and dependence, create boundaries between themselves and workers. This "boundary work" involves constituting and re-constituting their own identities, constructing layered, yet porous boundaries that include *and* exclude intimate employees, especially the foreign (Lan 2003: 546). Ethically speaking, these interactive processes ultimately serve to undermine respect and perpetuate inequalities.

The practice of recognition can help to respond to the harm done through global social economic processes, privileged irresponsibility, and the tendency to perpetuate divisions between "us" and "them." Building upon the notion of respect for persons, recognition has been theorized as a moral capacity that can be expressed in several interrelated senses, including recognition of another as an autonomous individual deserving of equality; an individual's unique identity; persons as being members of and in association with particular communities or groups; and others' needs for relationships and belonging, both interpersonal and associative (Gould 2007a, 2008).

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Recognition of nurses, nurse aides, and home care workers as persons, their structural position, of the inevitable asymmetries mediating all interactions, should serve as starting points here; and from there, recognition of the conditions under which they have migrated, under which they have taken a particular job, and of their goals for migration. Their expertise and experience warrant recognition, as does their capacity for decision-making authority on the job. Recognizing migrant care workers should include explicit acknowledgment that many live in transnational families and are parents, children, and partners of people living apart from them, and citizens of another society. It should include acknowledgement that they suffer from the fracturing of relationships, social exclusion, and perhaps a lack of belonging and stability (social, financial, legal) as a result of migration. It should include appreciation for their need to form new relationships, and to seek out certain services and forms of assistance. Also important is recognition of the fact that many migrants feel silenced under the most serious conditions of inequality and uncertainty, and may even hide concerns and abuse. Their unequal structural positions shape their subjective dispositions, undermining their agency. Family caregivers should support them in encouraging them to ask questions and express concerns. And crucially, family caregivers owe recognition of a care worker's contribution to the family and to the society in which she's employed, most likely as a low wage, highly vulnerable worker. A fourth dimension here is recognition of the places from which migrants come and those in which they provide care. I am using "place" broadly here to refer to source countries—the societies themselves—and their health care systems, as well as the workplace conditions in which migrant care workers find themselves.

Recognition manifests itself in many ways: Morally perceptive questions and acknowledgments, listening, offering fair compensation, and other forms of material support, supporting good working conditions, offering assistance in finding help to address harm and/or injustice, or helping to address it oneself.

Solidarity

For the most part, solidarity has been theorized as concerning relations among members of a particular group, region, or society. In particular, social solidarity traditionally understood focuses on community members who are vulnerable. Recent work on solidarity, though, attempts to expand it beyond its traditional sources of a national community. Carol Gould (2007b: 159), for example, conceptualizes it as an openness to cultivating relationships with a range of others who may not be one's compatriots or fellow group members, who are suffering.

Solidarity is often understood as involving fellow feeling, "feeling with" others or feelings of mutual concern. Yet affective ties, if they imply *affective affinity*, may not be the only or even a desirable basis for solidarity in societies characterized by pluralist moral values and social stratification. Iris Marion Young proposes a reconceptualization of the basis of solidarity that reckons with pluralism and asymmetries: It is not affect but rather the fact that people are situated differently yet still "dwell together . . . within a set of problems and [complex, causal] relationships of structural interdependence" (2000: 197). This grounds what she calls "differentiated solidarity."

Family caregivers seem ideally situated for differential solidarity with migrant care workers. Despite asymmetries, both confront disrespect and deepening injustices, and at

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the same time are told that their opportunities are expanding and they have ever-greater choice. Neoliberal economic policies have imperiled both, through cuts in public spending and shifting responsibilities for welfare increasingly onto families, especially women, who are responsible for both unpaid care labor and participation in the paid labor force, which for some, perversely, takes some away from their homes and families. The informalization and privatization of care is especially worrisome for migrant women given that it has thrust them into the kinds of work settings where they are most vulnerable.

Solidarity in this context should involve family caregivers advocating for more coherent and comprehensive coordination of care, labor, and migration policies. This would include attention to improved wages and working conditions for migrant care workers; immigration and other policies that improve social and economic status and more equitable access to social and political rights for all caregivers; adequate state support for working families and appreciation for the contribution of care work to the state, and not only as export; and finally, global health equity.

Preventive Foresight

"Preventive foresight" calls for cultivating a sense of responsibility by striving to anticipate and, to the extent possible, avoid injustice and crisis (Kurasawa 2007: 97). For starters, individuals and families with resources in wealthy countries might practice preventive forsesight. This would call for family members to plan ahead for long-term care needs and to think critically about their anticipated use of resources. They might ask themselves, for example: Is there a difference between our expectations for care and our needs? To what extent might these expectations or actual needs have harmful implications for care workers, as well as others in need of care abroad, such as their family members, communities, and the ill and dependent in source countries with health worker shortages? Could we plan and provide for long-term care needs in such a way that we might avoid or lessen participation in the perpetuation of injustice, even in the midst of a complex political and economic landscape that constrains our options?

Not only do families tend not to take the long view, but critics have observed that the future is strikingly absent from view in health policy, including long-term care policy planning (Graham 2010). Family caregivers, finally, should encourage policy makers to plan for the long term of long-term care, and more broadly, human health resource needs. In light of the issues raised here, thinking that goes beyond the confines of narrow nationalism is essential.

Conclusion

Long-term care raises questions regarding justice in health care resource allocation and workplace conditions, justice in families, global justice, as well as questions of justice that arise at the intersections of these areas. Here I have focused on one such question: What do family caregivers owe migrant workers who contribute to the care of their aging loved ones? I have argued that given their contribution (however indirectly and unwitting) to the injustices migrants suffer, their more privileged position, and crucially, the contribution made by these care workers to their identities, family members owe them recognition and solidarity, and for those who might but have not yet come, preventive foresight.

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