

Living in the Age of Austerity and Migration:
The Complexities of Elderly Health and Care

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Abstract

The Global Financial Crisis of 2008 has caused much dialogue within the social policy framework on how to maintain a sustainable elderly health care system. This coupled with a migrant crisis have created extra social and economic pressures in Europe in particular. As it has been well documented by social scientists, people are living longer than ever before. There are two fundamental factors that are helping people live to an old age, which are: (1) a better quality of life, and (2) improved health care system at state level. However, since the Global Financial Crisis of 2008 populations across the world are living in an age of austerity. The age of austerity has brought extra financial pressures on the state, polarizing society by implementing cuts in welfare. The reason many governments across the world (e.g. United States, United Kingdom, Greece) have enforced a series of austerity measures is fundamentally to reduce debt. The aim of this paper is to critically explore the austerity social policy agenda within the context of the debates surrounding the refugee/migrant crisis in the elderly health care system.

Keywords: Aging, Austerity, Global Financial Crisis, Migration.

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Aging and international migration are two prevailing global trends that have changed the age and ethnic composition of populations and bring exceptional challenges of caring to countries worldwide.

"The world's population is ageing rapidly at an unprecedented rate. The proportion of people aged over 60 years will double from about 11% to 22% between 2000 and 2050. Population ageing has profound implications for the burden of disease and social and health-care systems. How well prepared are countries to cope with these changing demographics? Unfortunately, current elderly care systems worldwide are already unable to address the soaring demand from fast growing numbers of older people, even in higher income countries." (The Lancet, 2014, p. 927)

As the above quotation from the medical journal *The Lancet* demonstrates, people are living longer than ever before, primarily due to improvements in standards of living and quality of health and care. It has been well documented by many scholars (Hyun, et al., 2016; Kudo, et al., 2015; Kelly, et al., 2014; Prettnner, 2013) that population aging has become a critical debate in the social science discipline. As Cook and Halsall(2012, p. 1) have noted:

"Over the recent decade, there has been much academic discussion on the rapid increase in population aging. Population aging has caused political challenges in the economic and social activities affiliated with a growth in the elderly population."

With population aging, its impacts on immigration, as well as elderly immigrants, have drawn policy and scholarly attention in both developed and developing countries. While the desire to migrate declines later in the life cycle, migration of the elderly follows primary migration for family reunification, return migration (e.g. Percival, 2013), and the mobility of certain specialist workers such as health and care providers may increase (e.g., Ferrer, 2017); no need to mention, the early generations of immigrants, particularly those as part of the big

immigration waves of the 1960s and 1970s, are approaching retirement age in those traditional immigrant receiving countries.

Looking at the statistics, in the United States, there were 46.2 million older adults (65 years and older) in 2014, including 6.4 million older immigrants; 14% of the foreign-born population were age 65 and above (Zong and Batalova, 2016). In Canada, older adults reached 5.78 million; immigrants comprised 30% of all aged 65+ (Gierveld, et al., 2015). In Australia, 36% of Australia's older people were not born in the country (Australian Bureau of Statistics, 2012). In Europe, recent Eurostat (2017) numbers show, older adults take 18.9% of total EU population; the number of people living in the EU-28 who had been born outside of the EU is 34.3 million, including 7.5 million in Germany, 5.4 million in the United Kingdom, 5 million in Italy, 4.5 million in Spain and 4.4 million in France. While immigrant populations are generally younger than natives, the number of older immigrants in the EU has never been underestimated (see Figure 1 for older immigrant population size and its percentage to total foreign-born population; OECD.Statistics only provides the data from the 2000 round of censuses).

[insert Figure 1 here]

For traditional immigrant countries such as the US, Canada and Australia, the growth of the foreign-born population aged 65 and above is driven by two trends: the aging of long-term immigrants and recent arrivals of a smaller number as part of family reunification and refugee admissions. Such history and ongoing immigration make projecting the future size of the elderly immigrant population challenging. For example, in the US, Carr and Tienda (2013) analyzed that during the 1990s, over 133 thousand new immigrants as dependent family members were age 50 and over, and between 1990 and 2009, one third of 5 million were considered as late-age immigrants; Treas and Batalova (2007) estimated that US older immigrants would reach 16 million and more by 2050. In Europe, immigration history varies

greatly across countries; in some old immigration countries, such as the Netherlands, aging is taking place among immigrant populations. Historical experience suggests that aging immigrant population could increase rapidly; for instance, data from Germany shows that over a 32-year period, the older foreign-born population aged 60 and over doubled roughly every ten years, from 3.1% in 1970 to 9.7% in 2002 (White, 2006). Meanwhile, countries like Sweden and Switzerland that also have an early take off of large scale immigration, aging is occurring but differently, reflecting within country migrant groups' characteristics, their time of arrival, and age at arrival (Ruspini, 2009).

Older Immigrants and Health Challenges

Common understandings of immigrant populations suggest that they are healthier than the native population. Health disparity research offers that “healthy immigrant effect”—recent arrivals (usually from low-income countries) have generally better health than the native (usually in high-income countries) or at least better given their socio-economic status—is primarily due to factors such as culturally based healthier lifestyle, stronger social network and support, and selection bias (i.e. healthy people migrate); such health advantages may gradually disappear along the process of acculturation (i.e. negative acculturation effect) (see reviews done by Ro, 2014; Malmusi, et al., 2010). For older immigrants, such health advantages might be maintained as return migration—particularly those return to countries of birth after retirement, being seriously ill, or a period of employment reflecting a cultural desire to die in one's birthplace—a negative health selection process contributes to overall immigrant health advantages at late age (also known as salmon bias) (e.g. Abraido-Lanza, et al., 1999; Riosmena, et al., 2013).

The “healthy older migrant” does not gain solid empirical evidence. Looking at health outcomes in the literature, in Canada, foreign-born older adults (55 years and above) did not

systematically report either better or worse health than their native peers (Newbold and Filice, 2006); in spite of the health outcomes, a scoping review done by Guruge, Birpreet and Samuels-Dennis (2015) indicates that the older immigrant women in Canada tended to have more health challenges, underutilize preventive services, and experience more difficulties in accessing healthcare services. In the US, Heron, Schoeni and Morales (2002) found that in the population aged 55 and over, the foreign-born reported general health to be worse than the US-born, but the immigrant-native differences with the same racial/ethnic background are large and usually in favor of the immigrant. In Europe, Solé-Auró and Crimmins (2008) studied 11 European countries and did not find much evidence of “healthy migrants” at ages 50 and above; instead, older immigrants have worse health than the native population. Further, while such “healthy migrants” were documented in some countries such as Italy and Germany, immigrants in other European countries including France, Belgium and Spain reported a poorer health status than natives (Moullan and Jusot, 2014; Zur, Nieden and Sommer, 2016).

Immigrant populations vary greatly in terms of ethnicity, race, social economic status, education, age of arrival, language capacity, family structure, and country of origin, all of which contribute to their wellbeing both physically and psychologically. In each country, different immigration systems have led to the diverse composition of immigrant groups. Given the nature of entry, while the inflow of foreign workers reflects a need of local market denoting an active (or positive, wanted, and healthy) migration, accepting asylum seekers and admitting migrants for family reunification are the state’s humanitarian responsibility; this is a passive migration as the country has no control over the characteristics of migrants. Keeping this in perspective, European countries have been coping with the growing number of refugees and asylum seekers from Syria, Afghanistan, Somalia, and other countries particularly in the 2010s (not to mention the European refugee crisis that began in 2015), and

received a large number of asylum seekers compared to the number of foreign workers they attracted (or wanted). Among refugees, some could be professional workers and economic migrants, such as those who migrated to Spain and Portugal in the 1970s and 80s as a result of civil wars in Latin America (Warnes, et al., 2004); but most of them are not. Compared to Europe, traditional immigrant countries like Canada, Australia and the US, benefiting from their geopolitics, have been able to receive a fairly low proportion of asylum seekers, and remain attractive to foreign workers (i.e. healthy migrants).

Overall, the big picture of older immigrants' health status is difficult to discern from the existing literature. Studies are highly fragmented with various focuses on specific health outcomes in certain migrant groups of people, compared with native peers or people in their countries of origin. Often studies are about general immigrant populations and age is a control variable; research has been published with a wide range of different sample sizes and methods and results, in some respects, are inconsistent. Furthermore, among the most common health concerns for older adults including arthritis, heart disease, cancer, respiratory diseases, Alzheimer's disease, diabetes, influenza and pneumonia, a quick snapshot of some studies (see Table 1) suggests an alarming picture. Elaboration of such health disparities leads to a broader array of social economic and cultural factors that either protect or jeopardize the health of older immigrants.

[insert Table 1]

Older adults who migrated as children or young adults and recent arrivals after age 60 face different challenges in their lives, which might result in different protective factors and barriers in accessing health and caring. Migrant health research has been making distinctions between foreign-born groups of people who migrated before age 20 and after (e.g., Colón-López, et al., 2008; Roshania, et al., 2008). Acculturation theories, despite proposing different trajectories, imply that long-term immigrants have several health protective factors

that correlate with the native population, such as use of preventive healthcare, language capacity, knowledge of navigating social and healthcare systems, welfare eligibility, health insurance coverage, and/or employment history. Across European countries where universal healthcare is mostly available, Solé-Auró and colleagues (2012) analyzed the Survey of Health, Aging, and Retirement database and pointed out that older immigrants used from 13-20% more health services than native people after controlling demographic characteristics; in details, assuming the same level of health care needs, differences between immigrants and their native peers in the use of physicians, but not hospitals, were reduced by about half; these results did not change much given the consideration of socioeconomic status and additional insurance. However, Franchi and colleagues (2016) found a lower rate of health care resource utilization observed in elderly immigrants who had been living in Italy for at least ten years; in Nordic countries, elderly immigrants used health care and old-age care to a lesser extent (Diaz and Kumar, 2014; Hjelm and Albin, 2014). In countries like the US where universal healthcare was not available and newly-arrived elderly immigrants are not eligible for Medicare (the government funded healthcare program for seniors), Choi (2011) indicated that the elderly immigrants' behavior of seeking healthcare was facilitated by having sources of care such as private insurance. The inconsistency of access to and use of health care among older immigrants reflects both individual (e.g. language capacity, and cultural belief) and contextual (e.g. insurance, and language service availability) level restraints.

Health Care Systems in the Context of Austerity

Given the growing number and proportion of older migrants, societies are pressed to respond to their needs in healthcare and caring. Many countries across the world, such as the United Kingdom, United States and Japan, have had to rebalance their social policy responses

to an ever-aging population. Moreover, social policy makers and politicians have had to rethink strategies of how to create a sustainable social and economic policy for an aging population (Newbold, 2015). While an aging society can see a welfare reduction in its share of manufacturing output, immigration can ameliorate this outcome if it is directed toward younger immigrants. Replacement migration has been widely discussed among low-fertility countries, particularly Europe and the European Union (United Nations, 2001).

However, this discourse has not been helped by the events of the global financial crisis of 2008, as this event has created extra economic pressures on the state. For a long period of time now many countries across the world have been living in an era of austerity. Austerity measures can have a brutal impact on different aspects of society, and one area that has been hit hard in recent times is social health care for the elderly. For example, back in 2011 in the United Kingdom, a report carried out by Age UK stated:

"Care and support in old age has reached financial crisis. For years society has tolerated a care system that has gone from bad to worse, for lack of money. This is in spite of the dedication, professionalism and innovation of tens of thousands of people working in social care. Recent well-intentioned reforms have been an insufficient response to the deep-seated problems our care system faces, because they have been unable to tackle the underlying financial crisis. Radical funding solutions cannot now be avoided, and they will not be cheap. But although politicians from all parties acknowledge the problem there is as yet insufficient commitment to comprehensive reform."

(Age UK, 2011, p. 3)

This growing financial crisis in UK social health care is comparable with what has been happening in the other countries as well. For example, Matsuyama has warned that Japan could potentially 'face a full-scale crisis in the near future' (2014, p. 19) whilst in China research carried out by Song has discovered that the Chinese government 'is still not adequate to cope with the aging crisis' (2014, p. 114) and in the US it has been suggested by Lezzon that there are 'schisms between policies and programs serving elderly individuals' (2014, p. 64).

With these concerns also comes the issue of immigration. Over the last decade there has been much political discussion regarding the impact migration has on a particular country. Recently, the political concerns on migration have intensified due to global political events, such as the US Election (2016), the UK European membership referendum and the ongoing Syrian Civil War. In many ways social scientists would describe these political events as anti-establishment and the rejection of free market liberal globalisation. The day after the 2016 US presidential election, Robert Shrimley in *The Financial Times* noted that across the US:

"Mr Trump touched a chord with the angry, working class, white mainstream who have seen the certainties of their world fade with globalisation, with free trade, with technology and with the sense that America no longer punches its weight in the world." (Shrimley, 2016, p. 8)

The global political events of 2016 have caused social scientists, policy makers and politicians to consider whether we are living in an age of anti-establishment. In 2016 there were two political events that have created a cause of concern: (1) the election of Donald Trump as the 45th US president, and (2) the UK deciding to leave the European Union. Hobolt (2016) has provided a useful explanation of why so many UK voters wanted to leave the European Union:

"The anti-establishment message that made the Brexit Leave campaign so effective has also led to electoral successes of populist parties across Europe in recent years, generally fuelled by worries about immigration, lack of economic opportunities a danger with the political class."

It has been well documented in the world press that this tsunami of anti-establishment politics is the failure of states across the world to respond to the Global Financial Crisis of 2008 (Heffer, 2016; Frank, 2016). Current literature on the subject of economic stability has suggested that people from middle and working class communities across the world have failed to benefit from the global financial recovery (Dorling, 2015; O'Hara, 2015). The key

blame factor in the voters' eyes is the state. Voters are currently pessimistic towards the state and are reluctant to vote for the traditional political parties of the left and right. The modern political voter is reaching out to a new kind of political party that is willing to take on the political establishment. Research carried out by Hanley and Sikk (2014) identifies the creation of new political parties in Eastern Europe that make specific reference to the anti-establishment political movement due to events of the global financial crisis. Hanley and Sikk (2014) have coined the term 'anti-establishment reform parties' (AERPs) and these anti-establishment parties are seen by the voter as mechanisms to alter the way politics is conducted. Moreover, Hanley and Sikk (2014, p. 525-526) have provided an analytical explanation of how in the current climate of anti-establishment political parties are created: (1) *Crisis and economic hard time*, the recent rise of anti-establishment parties across Europe as a response to the pressures exerted by the global economic downturn and the Eurozone crisis, (2) *Perceived corruption and distrust*, in contrast to explanations which foreground economic recession and growth in unemployment, the rise of anti-establishment parties as a crisis of confidence in conventional democratic politics and the honesty and competence of elites, and (3) *Political conditions*, in this sense is seen party-electoral context, including the presence of strong radical (right) populist parties and electoral turnout.

This academic debate on anti-establishment is nothing new. There have been many social scientists (e.g. Doreen Massey, Stuart Hall, David Harvey) in the past who have drawn upon the Marxist ideas of anti-establishment. Furthermore, in many ways the term anti-establishment can be seen as interchangeable with anarchism. Anarchism as a political concept is understood as a philosophy that promotes self-governed societies where the foundations lie on voluntary institutions. Both concepts (anarchism and anti-establishment) have a highly critical stance on the state (Cook and Pepper, 1990) and political leaders/the state will be required to respond to the current political environment. Before the Global

Financial Crisis of 2008 and the uprising of the anti-establishment political social movements, political leaders and scholars were in many political quarters championing the concept and the success of the 'Third Way' within the state. There has been much political and social policy discourse on the relationship between the state and the 'Third Way' (Keman 2011; Turner, 2005; Powell, 2000; Connelly, 1999). Anthony Giddens who was one of the first sociologists to coin the term 'Third Way', defines the concept as:

"a framework of thinking and policy-making that seeks to adapt social democracy to a world which has changed fundamentally over the past two or three decades. It is a third way in the sense that it is an attempt to transcend both old style social democracy and neoliberalism." (Giddens, 1998, p. 26)

The concept of the Third Way can be perceived as a political ideology that mixes together the political ideologies of Socialism, Liberalism and Social Conservatism. At the core of the Third Way is the strong belief that the state is fundamental in addressing the social and political problems at a global, national and local level.

With all the theoretical debates, in practice, austerity and anti-establishment have resulted in huge changes in policies of health, elderly care and immigration. In the field of health, various measures of reductions in public spending on health and elderly care are common across the Organisation for Economic Co-operation and Development (OECD) countries (Quaglio, et al., 2013). In the case of Greece, which, being hardest hit, the government expenditure on health was reduced from 6.9% of GDP (70% of total health expenditure) in 2010 to roughly 5% of GDP (60% of total health expenditure) in 2015 (see Figure 2 for statistics of selected ten OECD countries, which are major immigrant arriving and receiving countries); what is more worrying is that after the financial crisis, the rates of growth in health expenditure stagnate, concurring with OECD's findings (2015). OECD published a working paper that assessed the short-term impact of economic crisis and austerity on health, and indicated that countries impacted hardest by the economic crisis have

witnessed the biggest health expenditure cuts; the fall in GDP from 2008-2010 was associated with cuts in healthcare expenditure (van Gool and Pearson, 2014).

[insert Figure 2 here]

Instead of cutting the government spending, most countries adopted practices such as increasing the out-of-pocket payment, reducing salaries of medical professionals, reducing the services and supplies, and health care privatization (Pavolini and Guillé, 2013; Karanikolos, et al., 2013). In Spain, for instance, to avoid the cut of health care expenditures, the conservative party passed a new health care law, considered the largest changes in Spain's national health service; the law is not only for cost control such as increasing co-payments and limiting the undocumented immigrants' healthcare access, but also structurally shifts the country's universal healthcare scheme to a contributory system (Gaffney, 2013). Such structure shift generates profound impact on the future of European welfare states and similar signs about the long-term negative impact of austerity on health have emerged (e.g. Quaglio, et al., 2013).

Government expenditure for the elderly care, despite the increase of elderly population, has also been facing similar devastating decline in the context of austerity and anti-establishment. Age UK (2011) reported that the number of older adults receiving home care has fallen by a third since 2010; the gap between needs and service supplied is reported at about 5 billion pound, and services that have long been part of the basic social fabric are disappearing at speed, for instance, 46,000 older people have lost their access to meals on wheels since 2012 (Harris, 2016). For long-term care, in countries including Finland, Spain, and the UK, the policies make the access to long-term care services more difficult (Waldhausen, 2014). Under the financial restraint, traditional welfare states are undergoing transitions particularly in the field of elderly care; the contracting out of services has been widely adopted, and privatization of social services prevails (e.g., Stolt, Blomqvist and

Winblad, 2011; Anttonen and Häikiö, 2011; van Hooren and Becker, 2012; Szebehely and Trydegård, 2012). For instance, in Sweden, one of the most generous countries in terms of its social welfare program, public resources for eldercare in relation to the number of people aged 80 and above in the population were reduced by 14% between 1990 and 2000 (Szebehely and Trydegård, 2012); in the area of home-help services and residential care provided to senior citizens, the proportion of private providers increased from 1% in 1990 to 16% in 2010 (Stolt, et al., 2012).

What has been interesting to note is the contradiction regarding the adoption of marketization and/or privatization of elderly care. Unlike social services provided by governments in other areas, such as childcare, the trend of decentralization, privatization, or simply 'going market' has been notable in the field of elderly care; this was occurring even before the financial crisis, the adoption of austerity policies and/or the political success of anti-establishment (e.g. the election of Donald Trump) (van Hooren and Becker, 2011; Quaglio, et al. 2013). The trend nonetheless reflects transitions among European country governments from universalism welfare systems to neoliberalism privatization/marketization (Schwiter, et al., 2015). In western societies, the caring role of the family has not been prioritized in their development of national elderly care systems. In fact, in Esping-Andersen's (1990) ground-breaking book that proposes three welfare regimes (liberal, conservative, and social democratic), 'de-familiarization' is considered a basic component of industrial and post-industrialized societies. Thus, government/public responsibilities for elderly care had been established and programs and services have been expected across most western developed countries. However, the growing elderly population and increasing life expectancy, the perception of elderly care as a costly social service instead of an economically benefiting social investment, the government desire to control the cost, as well as the increasing elders who want to 'age in place' have led to the increased policy emphasis

on the family role and family caregivers (e.g. Anttonen and Häikiö, 2011; Bookman and Kimbrel, 2011); privatization/marketization of elderly care is not only a viable approach for policy makers but also offers higher quality care in some aspects (Stolt, et al., 2011), which provide justifications for reducing elderly care responsibilities in the context of austerity.

Policy austerity, anti-establishment, and immigration reforms have maintained an interesting relationship. International migration in the last 15 years has become an isolated part of globalization; international migration and controlling national borders, as the state's sovereignty, have been managed by and large as a domestic issue and restricted in general by many countries (Peters, 2015). Over decades, the state's domestic policies have been swinging between pro migration and restriction given domestic-level variables, such as: job and domestic labor market; public anti-immigration sentiment; financial and budgetary benefit or burden placed on the public welfare system, to name the major ones. Notably, all these major variables have been in their full play against a positive policy environment for older immigrants in recent years. While immigration has supported economic growth in numerous European countries in the early 21st century, in the context of the economic downturn, immigrants have been disproportionately negatively affected in employment; immigration dropped, for instance, labor migration in Spain dropped from 200,000 in 2007 to 16,000 in 2009 (Collett, 2011). Public worries that European societies might not be able to sustain previous levels of immigration; large scale immigration unravels national identities, and undermine the solidarity (Collett, 2011). Gains of far-right and anti-establishment groups in elections and political debates not only are the success of turning such public worries into a strong anti-immigration sentiment, but also reinforce a policy shift from immigrant integration and multiculturalism to policies focusing on improving the 'employ-ability' of immigrants, the promotion of pay-to-go programs (e.g. voluntary return programs) and the maintenance of social and economic integration (Akbari and MacDonald, 2014; Sala, 2013).

Coping Global Aging and Migration

A few years after the financial crisis and Great Recession, almost a decade long experience of policy austerity, and recent wins of anti-establishment political parties in major western immigrant receiving countries suggest that the older immigrants' wellbeing as well as the framework to care for this growing group of the population are at a critical juncture. While a number of countries could have reconfirmed their primary national objectives in the midst of economic, political and social uncertainties, several others are experiencing a series of dramatic changes in social and immigration policies, both in terms of budget and priority. True, the development of a care system that responds to a changed and changing demographic structure and population composition, also taking into consideration of the cultural and migration background, is a huge challenge. Given the complexity of elderly care, migration (particularly the current refugee crisis in Europe), and political environment, depending on state initiatives to build an aging and immigrant friendly society at the present stage seems pessimistic. However, many scholars view the policy austerity and anti-establishment as an opportunity instead of as purely a threat. There are tangible steps and strategies states and political parties and leaders can take to help move the society forward, and decide how many resources should be allocated and the types of social policies that should be implemented to tackle problems in a community.

Firstly, policy austerity and anti-establishment are not necessarily occurring at the same time; similar to the efforts and discourse of the Third Way, states and policy makers need to respond in a way that transcends the universal pressure for cost reduction and the need for high-quality care. In the case of health and care for growing numbers of immigrant older adults across most developed countries' welfare states, states and their political institutions have the motivations and capacities to seek policy innovations and theoretical

alternatives of welfare states. Jessop (Jessop, 2016, p. 16) observed that examining the state in the current political framework is somewhat complex, and interpreted the state, as:

"[...] a complex ensemble (or, as some scholars put it, assemblage) of institutions, organizations, and interactions involved in the exercise of political leadership and in the implementation of decisions that are, in principle, collectively, binding on its political subjects. These institutions, organizations, and interactions have varying spatiotemporal extensions and horizons of action and mobilize a range of state capacities and other resources in pursuit of state objectives."

The above explanation from Jessop (2016) evades the idea that the state is a democratic process but emphasizes political institutions' drives and forces in an ever-changing world.

The conceptualization of welfare states has been developed and based on citizenship within country-state and the typology of welfare states reflects each country's efforts to de-commodify social services for all citizens (Esping-Andersen, 1990). However, granting a newly arrived migrant the 'citizen' status in the sense of welfare rights has been debated in the context of globalization. While social democratic welfare states generously provide 'citizen' status to immigrants in accessing health care, education and other various social services, liberal welfare states have picked up a hard line; for instance, in the US, legal immigrants wait for five years to be welfare eligible (note: legal immigrants can become naturalized citizens after five years in the US). It is understandable that uncontrolled migration would challenge country-state's social protection and social service finance, as well as the commitment to de-commodification of social services. A study in France indicates that a selective migration policy (i.e. preferred age and skill structure of immigrants) would bring in short-term financial gains to the migrant receiving country; but additional consequent migration flows, i.e. flows of older immigrants, would result in an increase in pensions and care expenditure, thus financial gains are moderated in comparison with demographic changes implied (Chojnicki and Ragot, 2015). Sadly, immigration is often viewed as an

instrument of adaptation for aging societies; in the US, immigrants contributed an estimated \$115.2 billion more to the Medicare Trust Fund than they took out in 2002-09 (Zallman, et al., 2013). But country-states have limited interests in assuring the wellbeing of aging immigrants.

Countries including social democratic welfare states Sweden, Denmark, and Finland are increasingly pushing back against calls to accept more refugees amid fear that it could undermine stretched welfare systems, national integration and quality of life; Britain's departure from EU and Trump's victory in the recent election imply the country-state worry of controlling borders and defending against an immigrant influx. The challenge is becoming particularly acute, as country-states could be either successfully modifying their welfare state commitments or withdrawing, though not completely, from the process of a true globalization. Seeking viable alternatives to welfare states, or new typologies of welfare state beyond Esping-Andersen's work, is not new. Feminist scholars have long criticized the conceptualization of de-commodification, as it does not reflect women's efforts of equally participating in the labor market. And, work family policies as well as caring policies have been left out of the mainstream welfare state denominators; as a result, gender-based typologies have been proposed and welfare states could be defined by the level of familialization or de-familialization (e.g. Saxonberg, 2012). Given the aging and immigration scenario, could it be possible to have a new typology?

There is an unwillingness in western welfare states to think about the implicit welfare contracts between generations. While the generational obligations of elderly care have been the cornerstone in some countries and culture, for instance filial piety in Asian culture, the rhetoric of resource redistribution and *welfare for justice* has been overriding values of long-term reciprocity. In other words, while welfare states have a pension system that current working adults support the current senior citizens, there has been little assessment and

discourse regarding how well society has handled the trust that successive generations have placed in the pension system by making contributions. Conceptualizing the welfare state with the incorporation of generational obligations might offer viable arrangements to care for the growing size and diversity of the elderly population. Modern democracy and welfare states centralizeresources and enforce nationwide welfare eligibilities; doing so increases the potential of promoting equality and encourages efficiency and mobility, but also carries the messagethat the care responsibility has been de-personalized and de-generationalized. It is noted that both older immigrants who have naturalized and thus become eligible for public programs of support, and older newcomers who primarily depend on their families for financial support, care and assistance in everyday life, play important roles in immigrant families, and conversely, families are relying upon older immigrants for caring for grandchildren. The new interests in welfare decentralization, flexibility and re-familialization, not only among policy makers but ordinary people as well, could help build a welfare state with redefined roles played by the state, community and family.

In addition to policy innovations, in practice, to meet older immigrants' needs in health also relies upon a society's commitment to multiculturalism and efforts in integration. In practice, elderly immigrants have a limited capacity to communicate their health issues, needs of care, and concerns in daily life due to language capacity and cultural beliefs, which create a certain amount of vulnerability to serious health and care issues as well as health disparities. Multiculturalism models posit that immigrant communities will feel increased connection to and engagement in the broader society by recognizing and accommodating minority/immigrant culture. Policies and programs designed to positively recognize diversity and cultural heritage would help minorities maintain culture and tradition and facilitate their lives in the receiving community. Multiculturalism models and policies had been considered as best practices; even liberal welfare states like the US have policies and programs that are

to mediate class, race, ethnic and gender relations, to give stimulus to ethnic-based networks of mutual assistance and protection, and to train healthcare and other service providers with cultural competence and language capacity. Such programs and policies are not only necessary but also essential to the wellbeing of older immigrants. It is fair to say that existing or previous multicultural and integration policies and programs have generated an overall positive environment for older immigrants who have stayed for a longer period of time.

However, over the last decade, integration and multiculturalism efforts have been viewed too expensive, unaffordable and failed. Policy austerity and attacking multiculturalism have dominated many policy reform efforts across immigrant receiving countries. What further worsens the policy environment for older immigrants is that among the immigrant receiving countries, state governments often leave such immigrant integration and multiculturalism tasks to their social welfare systems. Restricting welfare benefits for immigrants has been the centerpiece of policy austerity, something that resonated with public anxiety and worries concerning the consequences of immigration; welfare state fatigue that relates to both economic globalization and immigration has become evident in many welfare states. In the context of economic recession and policy austerity, the political supports for immigrant-focused social programs are weak (Gietel-Basten, 2016); remaining efforts in most countries are mostly on labor immigration, which has further sidelined the issue of how to care for older immigrants, particularly newly arrived older adults (Benton, et al., 2014). Welfare state retrenchment and anti-immigration might have changed states' commitment towards multiculturalism; but the situation and wellbeing of older immigrants depend on high quality care professionals and ethnic community assistance.

Conclusion

The changing face of aging in the context of globalization and international migration has transformed the issue of health and care from a domestic one to a global one, and in turn has generated questions about the issues of health disparity, diversity in needs of care, and traditional approaches to health care and elderly care. In the political context of policy austerity and anti-establishment, it is not just about political parties and elite decision-making processes; it is about public fear and disdain concerning issues like borders, culture, and the national identity. With much research that indicates the long-term benefits of immigration and limited research into the relationship between aging and immigration, the danger and risk of getting into a situation, that welfare states are giving up their commitments and investments in social services and multiculturalism, could lead to a tragedy of humanity. With weak leadership across most welfare states and immigrant receiving countries, two strong social political trends—(1) the growing demand of immigrants and older adults leading to a necessity of individualization of care, and (2) the continued need for austerity thus shirking of state responsibility—likely result in the lack of structural failure to cope with the growing aging and immigrant populations. Thus, the task is to seek innovative reconfigurations of social welfare systems. The effects of this reconfiguration process might be especially pronounced among those who are used to a more robust welfare state, but such alternatives would address who and what bears responsibility for the health and wellbeing of older immigrants (including newly arrived older asylum seekers), as well as each country's own less enfranchised citizens.

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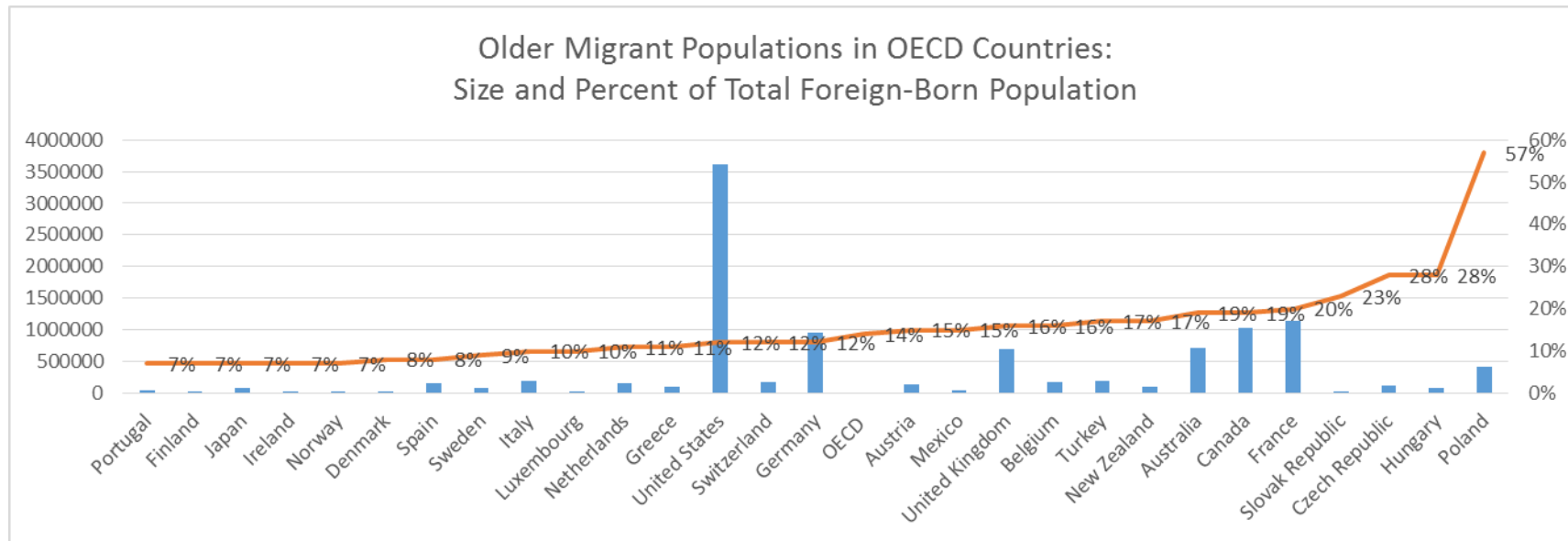
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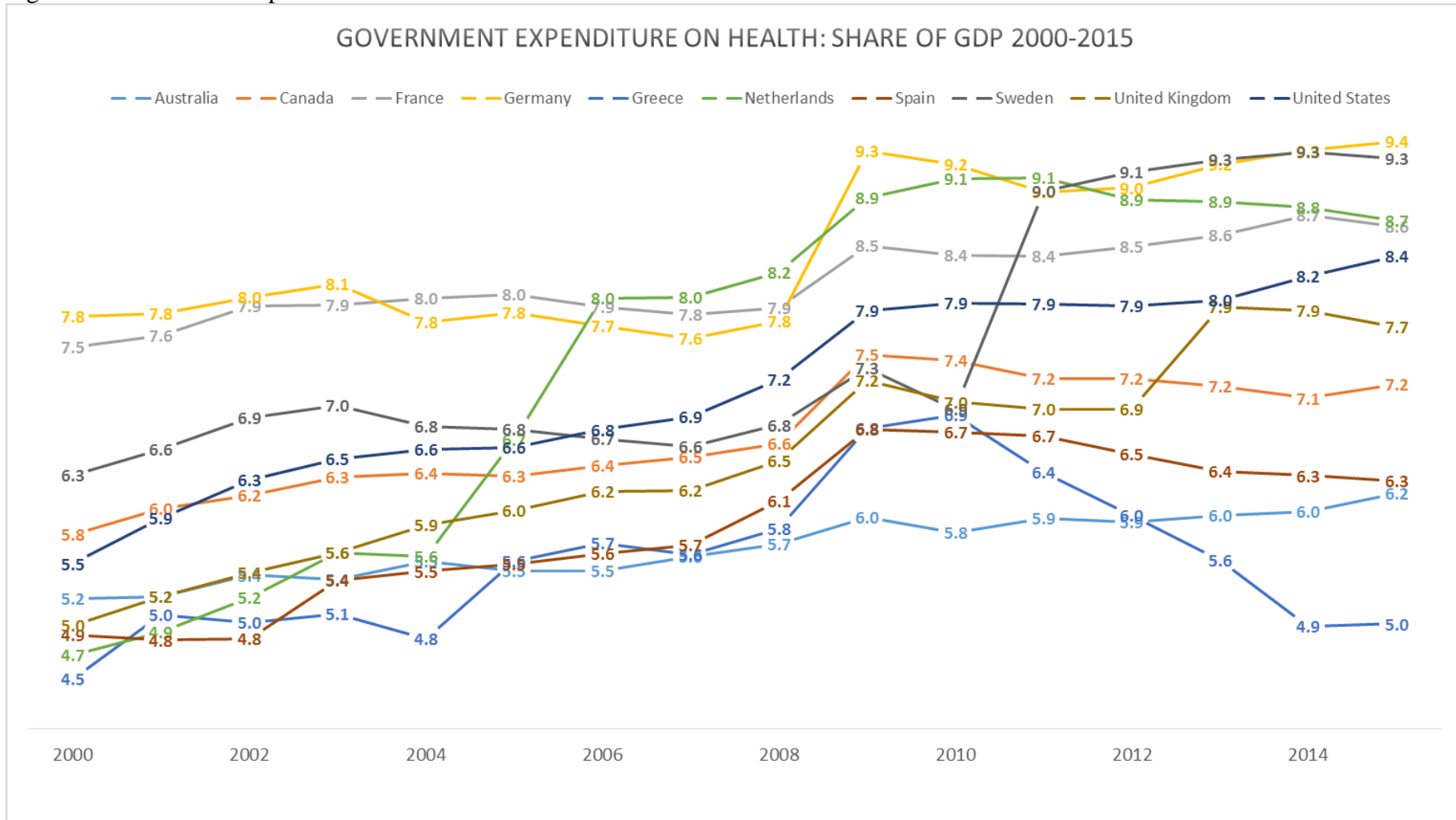
Figure 1: Older Migrant Populations (65 years and above) in OECD Countries



Data Sources:

OECD.Stat Table: Immigrants by sex and age. The sources for this database are mainly census data, from the 2000 round of censuses.

Figure 2: Government Expenditure on Health in Selected OECD Countries: Share of GDP 2000-2015



Data Source: OECD.Stat Health Expenditure and Financing

Table 1: Selected Health Outcomes of Migrants in Selected Countries

Health Outcomes (Prevalence)	Age	Migrant Group	Comparison Group	Results
Heart disease				
Lê-Scherban, et al. (2016)	45-84	Foreign-born in the US	Native-born American	+& - ¹
Jin, et al. (2017)	45 & up	Chinese in Australia	Non-Chinese Australian	+
Koochek, et al. (2008)	60-84	Iranian in Sweden	Iranian	-
Influenza vaccination coverage				
Jiménez-García, et al. (2008)	>65	Foreign-born in Spain	Spanish	-
Karki, et al. (2016).	>=49	Foreign-born in Australia	Australian	-
Diabetes				
Viskum& Pedersen (2016)	20-79	Non-Greenlander	Greenlander	-
Weijers, et al. (1998)	28-84	Surinam, Turkish, Moroccan in Netherlands	Dutch	-
Venkataraman, et al. (2004)	>60	Asian Indian in the US	White Hispanics and Black in the US	-

Note:

Results: “+” refers to “migrant group is better”; “-” refers to “migrant group is worse”; “o” refers to “no significant difference”.

¹ + for immigrants with shorter stay; - for recent arrivals as their heart health declined faster.