Till death do us Part: experiences of migrant live-in care workers facing the death of their care recipients – a study from Israel

Palliative Care & Social Practice

2025, Vol. 19: 1–12

DOI: 10.1177/26323524251326105

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Abstract

Background: As ageing in place becomes more widespread, the burdens on relatives of older people at advanced stages of illness, particularly those reaching life's end, become greater, requiring a level of support and responsibility that often exceeds the families' abilities. A common solution is employing live-in care workers, frequently migrant workers.

Objectives: This study explores how live-in migrant care workers experience and cope with their care recipients' end-of-life and death phases.

Methods: This study is based on an ethnographic study that included 37 interviews with live-in migrant care workers employed in the homes of older adults in Israel.

Results: We identified four themes: (1) Loneliness and fear due to the need to make decisions; (2) Devotion; (3) Trauma, loss and disenfranchised grief; and (4) The impact of the national immigration policy. The first two themes related to the care workers' pre-death experiences, the third their post-death experiences and the last extraneous factors affecting end-of-life care.

Discussion: Live-in care workers, often the last to accompany their care recipients in their final moments, develop a sense of devotion and responsibility, often leading to feelings of fear and loneliness. Their lower occupational status and sociocultural foreignness affect them in the pre-death and post-death phases. The local immigration policy also influences their motivation to work with palliative patients.

Conclusion: Applying a feminist critical social care perspective, we recommend policy and social attitude changes regarding live-in migrant care workers' role in end-of-life care.

Keywords: ageing in place, disenfranchised grief, feminist critical social work, homecare for older adults, live-in migrant care workers

Received: 27 June 2024; revised manuscript accepted: 19 February 2025.

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Introduction

As ageing in place becomes more prevalent in many parts of the world,[1] individuals and families take more responsibility for caring for family members who need palliative care. When the burden of care exceeds what families can manage while maintaining care at home[2] one solution is to employ a live-in care worker.[3] As part of their job, live-in care workers frequently accompany their care recipients through the last stages of life and death.[4,5] Since citizens of Western countries tend to be reluctant to take on 24/7 jobs, homecare workers are often migrant workers or recent immigrants.[6]

One of the significant characteristics of live-in care work is that it is a highly personal, one-on-one job. Unlike institutional settings where care workers interact with multiple patients and colleagues[7–9] live-in care workers usually have only one care recipient and work alone, with the care recipient also being their employer. This live-in situation invites intimate, intense and complex employer-employee relationships. The death of a care recipient can be a significant personal and professional event for the care worker, who may have formed a deep attachment to the recipient and found a sense of purpose in their caregiving role.[10,11]

Home has surpassed the hospital as the most common place of death in many countries, including the United States[12] and live-in care workers play a vital role in enabling care recipients to remain at home. However, there is a lack of research regarding their role and experiences during palliative and end-of-life care.[13–17] While previous research on care workers' experiences and strategies for coping with death has focused on organisational settings, such as nursing wards, there is limited information on live-in care workers' experiences and perceptions regarding end-of-life care. Based on a study conducted in Israel, this paper aims to narrow this gap by exploring how migrant homecare workers experience the death of their care recipients.

Theoretical framework

Feminist critical social work theories offer important perspectives into the complex dynamics between migrant care workers and care recipients. This theoretical framework emphasises interdependence and relational responsibilities and promotes contextualised decision-making in care practices.[18] From a critical perspective, homecare relationships are shaped by power imbalances and the devaluation of care work, which is often performed by marginalised women.[19] The intersection of race, gender, class and immigration status creates unique challenges and vulnerabilities for migrant care workers,[20,21] including in end-of-life care situations where racialised power dynamics shape the interactions and emotional labour required of live-in migrant care workers.[22,23]

The outflow of workers from poorer countries to care for older people in affluent countries has become an indispensable part of the global labour market and the globalised economy of care.[6] Migrants are often vulnerable to exploitation and sometimes forced to accept employment conditions that would be unacceptable to the local population.[24] At the same time, the largely feminised workforce continues to provide for families in their home countries, both through remittances[25] and by engaging in involved, active motherhood through new technologies.[26] The expectation that they take care of both their care recipients and their families back home places a heavy burden on migrant mothers,[27] often leading to a 'care drain' in communities and the formation of 'care chains' to provide substitutes for the exhausted migrant women.[6,28]

Context: Live-in migrant care workers in Israel

The present study took place in Israel, where life expectancy is among the highest in the world.[29] Nevertheless, Israel's government's expenditure on long-term care is low relative to most OECD countries.[30] The vast majority (97%) of Israeli seniors live in the community and over 20% of them benefit from formal home-based care services. Most (87%) of those receiving these services live and are cared for within the community, supported by extensive family involvement.[31–33]

The employment of live-in care workers by private individuals who wish to remain in the community is encouraged through the 1988 Long-term Care Benefit Law, which financially supports home care through the National Insurance Institute.[31,33] To employ a live-in migrant care worker, one must obtain an employment permit and permits are granted to people who require assistance in performing activities of daily living based on functional dependency assessment tests carried out by the National Insurance Institute.[30,32] There are approximately 100 certified private employment agencies specialising in the placement of migrant live-in care workers in local families in need. These companies are legally mandated to employ social workers responsible for conducting home visits and monitoring the well-being of both employees and care recipients.

In 2022, there were 70,000–80,000 live-in migrant care workers in Israel originating from the Philippines (35%), India (25%) and Uzbekistan (15%). The most common age group across all labour categories is 31–40 and the majority (83%) are women.[34] Migrant care workers may be employed full-time only, and their employers must provide them with home residency.[35] The workers are entitled to the same social benefits as Israeli workers, including minimum wage, medical insurance and dismissal conditions. An employer's death is considered a dismissal and entitles the worker to one month's salary from the day of death. The local immigration policy is based on, among other things, preventing non-Jewish immigrants from settling in the country,[36] and offers no pathway to citizenship or permanent residency for migrant workers, nor does it allow them to have a spouse or children working or living in Israel.[35] Migrant care workers receive a 1-year visa that can be renewed annually for a period of 5 years and 3 months or until the death of their last care recipient.

Method

The present study is based on a qualitative study of home care for older people in Israel.[7] The study consisted of interviews with 37 migrant care workers employed in the homes of older adults, as well as interviews with family members who employ care workers and service providers. The interviews were conducted by Author 1 and thematically analysed. The present paper focuses on one of the key themes that arose from these interviews: the experiences of live-in migrant care workers regarding their care recipients' deaths.

Participants and data collection

The live-in care workers who participated in the study were primarily women (90%) aged 28–45 ($M=37$), all from India. The average employment time prior to the interview was 3 years (ranging from 8 months to 8 years). Participants could determine whether interviews would be conducted in their residence, a public place near their residence, or any other site of their selection. To follow up on processes and changes that occurred with time, repeat interviews were conducted with nearly half of the participants. The semi-structured interviews began with a few basic questions but evolved into an open-ended conversation with the interviewee. The questions related to their motivations for coming to Israel, their daily lives as caretakers, their relationships with the families that employed them and their future plans. The interviews lasted 40–80 min.

Analysis

The study used a reflective thematic analysis process.[37] Following the initial coding of the transcripts and a themes derivation process, we found that a key issue that emerged from the data was care recipients' deaths. After deciding to focus on this topic, we re-read the interview transcripts and aimed to identify key themes related to it. The aim was to discern themes in the interviewees' experiences and present them in a way that would facilitate theoretical development and practical understanding.[38] This was performed as a reflective, critical conversation between the three authors. All the writing partners contributed to the formulation and naming of the themes. Each category and the interpretive claim were repeatedly checked and developed through a review of the transcripts in search of examples, exceptions, variety and nuance.[39] Furthermore, each interpretive statement was accompanied by an illustrative verbatim quote.[40] We chose to focus on a primary representative example for the illustration of each theme, accompanied by shorter quotes from other interviews relating to that theme.

Ethics

All names and identifying details have been changed to protect the identity of those involved. The interviewees were recruited voluntarily and were informed of the study's objectives. All participants signed informed consent forms. The participants were assured they were free to withdraw from the study at any point. During the interviews, we were mindful of paying attention to any signs of anxiety in the participants, particularly as some participants were recently bereaved. Consequently, we were ready to stop the interview at any point if necessary. The participants were also assured that their responses would remain confidential and that the interview would be analysed anonymously.

Creating close long-term relationships with a group of excluded women, going out into the field and meeting them in their surroundings, such as homes, parks and churches, represents the relational method, which attaches importance to the connection created with the participants. Recognising their knowledge, giving voice to their experiences and turning them into a source of knowledge are all consistent with the ethical principles of feminist critical research.[18] The study was approved by the Ethics Committee of the authors' academic institution (no. 2022-52).

Results

The purpose of this study was to understand the experiences of live-in migrant care workers regarding the end-of-life phase and the death of their care recipients. The results are organised around four main themes: (1) Loneliness and fear following the need to make decisions; (2) Devotion; (3) Trauma, loss and disenfranchised grief; and (4) The impact of the national immigration policy. Below, we present and analyse quotes from interviews to elaborate on these themes.

Loneliness and fear due to the need to make decisions

The homecare situation calls for intense relationships between the live-in workers and the care recipients, who are also their employers. It often involves considerable intimacy that extends to the very last moment of the care recipient's life. Lisa's story illustrates this:

> I worked for her for two years and the woman was so sweet. We used to sleep in the same bed. . . She wanted that, we enjoyed being close to each other, we had some laughs. I felt as though she were my grandmother. . .. When she died, she was together with me in bed.

Drawing attention to the fact that her care recipient died when they were both in the same bed was Lisa's way of describing the bond she had with her previous employer. However, while Lisa's story was that of a peaceful death, one that she could do nothing to prevent or palliate, in other cases of death at home, there were decisions to be made. This was challenging, in particular when the live-in caregiver was the only person present at the time of death.

Anita was a qualified nurse in India. During the interview, she described the last days of Miriam, the older woman she had been caring for. Anita described herself as trying repeatedly to alert Miriam's children to her condition:

> For three days, she was very tired. I notified her son and daughter and I think they also notified the doctor and he sent a nurse. The nurse came in the morning and gave her an infusion, and both the daughter and son arrived. They all left after a while and I stayed home with her.

The care recipient's relatives heard Anita's pleas and the doctor sent a nurse for primary care. However, after some treatment was provided, they all left the house and Anita remained alone with the sick woman. She proceeded with her routine tasks but soon realised that Miriam's behaviour was not normal. She emphasised this feeling during the interview, and it seems that her routine actions were an attempt to keep the care recipient stable and maintain a sense of normalcy:

> I took her to the shower and took her to the kitchen afterwards and gave [her] food and medicine. . . and then I changed her infusion. Then after four p.m. I called the son and told him again that he probably would have to take her to the hospital because it doesn't look good. After all, she didn't want to get out of bed. He said, 'Anita, I'll come tomorrow'. I told him, 'You know, she's not well, maybe you can come and take her to the hospital'. He said, 'I know, I know, she'll be fine, I'll come tomorrow. . .'.

Anita went into more detail, emphasising her constant appeals to Miriam's children. She described herself as trying to perform everyday tasks but soon realised that she no longer heard Miriam's constant muttering:

> Ten minutes later, I was doing laundry. . . and when I came back to the room. . . she was quiet. . . I thought she was asleep because every day she slept during that time. I looked at her from the living room to the [bed]room – she was asleep. But I was also confused, so I came to her five minutes later and she was already dead. I checked her pulse.

Anita's story illustrates the complexities of being alone at home with a terminally ill care recipient. Being a professional nurse, she sensed the situation was terminal and asked for more support but was left to bear the responsibility on her own.

A similar account was given by Jenny, who described her confusion during Hava's (her care recipient) last days. Hava's daughters told her to call them first if their mother's condition deteriorates instead of calling an ambulance:

> They don't want hospital, they said, so I am at home with her. . . I gave her the medicine. . . but her breathing was not good. At night, I couldn't sleep well, so I went to her room to check her condition. . ..

Hava's daughters had decided that their mother would stay home, which meant that Jenny would have to bear the responsibility for anything that happened. When Jenny described this, she stuck to the bare facts without expressing any complaint. However, her recounting of her inability to sleep illustrates that it might have been a great burden.

Devotion

Another theme that emerged from the care workers' descriptions was the emphasis on their devotion to their employers, a devotion that sometimes extended to the moment of death. This was a central theme in almost all the interviews conducted with them. For example, when describing her routine, Narashtra, who was living with an older couple, described her devotion as being unlimited by time or space:

> But even in my sleep. . .. I'm also alert to their sleep. I need to be alert for them and I can hear when they move. I recognise which one of them is moving because they each have a different style of walking. When I'm in my room, I listen to what they do and how they are, so all the time, the family really appreciates me.

Some workers' accounts indicated that when older people entered the end-of-life stage, their devotion seemed to increase. Sindy described the last weeks of Sara's life:

> She was 15 days in bed, all the time. She couldn't move at all. It was hard for me to see her like this. She said to me – 'Help me' – I did what I could for her. It was painful for me. I couldn't see her like this.

Some described this devotion as unwavering, even when the care recipient's attitude was abusive. Linda's story presented a distinct example. She had been caring for Malka for 3 years and was having a hard time due to the serious abuse she was suffering from her employer. In the first interview with her, she cried bitterly when describing the way Malka was treating her:

> She keeps yelling at me. I can do nothing. If I cook something I like, she says, 'My whole house smells of paprika and pepper. . .'. If I wear a beautiful dress or leave my hair untied, she asks, 'Is someone coming to see you? Do you think you're beautiful? Do you want to show men your hair?'. . . If I'm on the phone with my family, she yells. . . And even when I go out with her, I'm not allowed to talk to anyone. . . She thinks I was just meant to serve her, as a slave or a maid. She says, 'You're mine; you must not go anywhere, just stay with me, you came only for me'.

A short while after this interview, Malka died. Following her death, another interview was conducted with Linda. She chose to describe Malka's last moments in detail. It happened after Malka was released from the hospital and the two of them – Linda and Malka – were alone at home. At night, Malka felt ill and Linda tried to help her:

> On the last night, she asked me to give her a back massage, and I did. . .. Then she asked me to turn her around, and I did. Then she asked me to help her get out of bed. . .. I brought her water and she stood and leaned on my arm, like a little child, and vomited. . .. She stood like that for two minutes and her breathing was not good. I put her back in bed and called her doctor and her daughter. On the phone, the doctor told me to press her chest, and I did, but her breathing was not good. . . and then she stopped breathing.

Despite the ongoing abuse Linda experienced, she did whatever she could to comfort Malka in her last hours and keep her alive. She was not a trained nurse, but she found herself in a situation where she received instructions over the telephone to perform CPR on Malka, who was dying in her arms, while the medical staff and Malka's daughter were on their way. When Malka's daughter arrived and decided not to take Malka to the hospital, Linda, being a religious person, felt even worse:

> The doctor and the daughter arrived quickly while she was still a little alive and he asked the daughter, 'Do you want to take your mother to the hospital?' And the daughter said no. Maybe she could have lived a few more days. It was hard for me to see her like that. I suffered with her, but I had stayed with her for three years and I had gotten used to her.

Linda did not forget Malka's abusive treatment of her. Still, when Malka was dying, she remained totally devoted and did all she could for her, including trying to resuscitate her. Similarly, it was hard for her to accept Malka's daughter's decision. Malka's death meant parting from a woman who had been a dominant presence in her life for 3 years. This sense of loss and its effect on the care worker's mental state was a third prevalent theme.

Trauma, loss and disenfranchised grief

In most accounts of the care recipients' deaths, the care workers spoke about their own sadness. In some cases, this was described as a deep grief, verging on personal trauma. One example of this was Marilyn's story. Marilyn took care of Fortuna, who lived with her single daughter, Gail. The three of them had a routine that Marilyn found very pleasant. She described her life with them as 'perfect':

> I lived there with Mum and her daughter, Gail. She's like my sister and Mum is like my [own] mother. I love this family very much. Everything was good there. . . A good salary too and a good job. . . She loved me and I loved her. . .. I cook everything at home for Mum and me and her daughter Gail who also eats with us. . ..

Death came very suddenly. One day, they were in the park together with friends, and Fortuna was laughing and cheerful. The following morning, Marilyn found Fortuna dead. This was a shock and a terrible trauma. Marilyn describes herself as going through a severe crisis:

> We went out for a walk. . .. Everything was okay. . . I took her to bed to sleep, as usual. In the morning, I pulled up the sheets and said to her, 'Mum, good morning'. She did not reply. . .. The doctor came and said she had died early in the morning. . . during her sleep. . . I cried so much. I loved her so much, she was like my mother. She was a wonderful woman. I was shocked for a whole month and didn't feel well. I stayed for a month with her daughter. Gail is like my sister. . . after a month, I had to leave to look for a new job.

Marilyn's grief was manifold: the loss of the older woman she called 'Mum' was compounded by the loss of a good job, the loss of the relationship with the employer's daughter whom she saw as a sister and the loss of living in a house and neighbourhood she knew and liked. Fortuna's death meant Marilyn had to start all over again, establish relations with a new family and become accustomed to new routines and a new home. Having to find a new job often also meant separating from friends since these friendships were based on geographical proximity and frequent occasions to meet each other when going out for walks, usually with their employers.

I met Sylvie just a few days after the death of her employer at the house of one of her girlfriends. She had the option of staying at her deceased employer's home for a while longer. However, she did not want to be alone there, so she asked permission to sleep at her friend's employer's home for several nights until she could find a new placement. She described the experience as follows:

> Mum isn't well. I cry all the time, she suffers, I couldn't watch it. . .. She was hurting so much. She was in the hospital. . . the bed was small and she was big and she couldn't move. She said: 'Take me home'. I couldn't. She said: 'Why won't you help me?' . . . It was so hard. . ..

This interview took place just after the 7 days of Jewish mourning (the *shiva*). Sylvie did not take part in the *shiva*, although she was invited to by her deceased employer's children.

> The *shiva* was at her son's house. He said to me: 'Come to my house. Don't stay home alone all the time, you're crying all the time. You don't eat, you don't sleep'. I said, 'No, I'm embarrassed when there are a lot of people'. . .. So now I came to stay here with my friend. I don't want to be alone in the house all the time.

These women experienced loneliness and grief. However, while the grieving family members had each other, their community and their traditions to support them, the care workers often felt estranged and, therefore, reluctant to join. They coped with their pain with little support, mainly from other care workers.

What made matters even worse for these workers was that their subsequent placements were often less than satisfactory. Most of the workers' narratives included descriptions of a 'very good' employer who died and was thereafter followed by several other employers who were 'mean' to them, 'shouted' at them, 'complained all the time', 'made them suffer', 'demanded to perform tasks' they 'weren't supposed to do', and so on. They felt abused by these interactions, and their distress only amplified their grief over the death of the previous 'good' employer.

The impact of the national immigration policy

The anxiety relating to what would happen after their employer's death was a fourth important theme raised by the interviewees. Like so many others, Emily had made considerable sacrifices to work as a care worker in Israel. She had left her 6-month-old baby and husband, as well as her own older parents, in India to travel to a foreign country. She needed the money: she had enormous loans she could never hope to repay without migrating to work. Based on her calculations, Emily intended to stay in Israel for at least 6 years to save enough for a better life back home. However, almost 4 years later, when her employer's health began to deteriorate, Emily had to devise a new plan. On the one hand, she was very attached to her employer and their family, but on the other hand, she feared that if her employer died a short while after her basic visa was terminated, her plans would be ruined:

> I want to stay in Israel for six years; four years and three months is not enough – one year only pays for the visa and then I have to pay for the university loans and then for my brother, so many expenses, so at least six years I need. If my 'mum' dies one day after 51 months, I will be the unluckiest person in the world. I'm waiting to see how Mum will feel in the coming winter in order to decide whether to take the risk and stay with her, or look for another job.

This type of calculation appeared to be quite common among the care workers. When they were offered a job, they discussed the pros and cons of this offer in terms of the care recipient's condition, estimated their life expectancy and assessed what it meant for their plans. A job was considered 'good' if the care recipient appeared to have a long life expectancy. Even when they thought that the pay was fair and the family members and accommodation seemed satisfactory, taking the job of caring for someone who they thought would probably pass away soon was not considered a good choice.

Before Narashtra left the country, when helping her employers find a worker who could replace her, she looked for a recent immigrant. She explained:

> Aba (heb. 'Dad') has cancer, so he will probably not last long. So I need to find someone who is new here, so they don't lose the visa when Dad dies.

In the same vein, Jisna, who had been working in Israel for more than 7 years when interviewed, said the condition of her employer had worsened lately and that this worried her a lot because she 'is not ready to go home yet'.

These concerns and calculations are the results of the work visa laws, according to which, after 4 years and 3 months (i.e. 51 months), migrant care workers can extend their work visa only if they are still working for the same employer who employed them before this period of time expired. Otherwise, they must leave the country. The result is that, as care workers approach that date, they begin to estimate their care recipient's life expectancy because if the employer passes away even a day after the 51 months comes to an end, they will not be able to get a new steady job in Israel.

Emily did not want to stay in Israel without a visa or to work as a substitute caregiver – one who constantly moves between jobs. Therefore, she was terrified by the prospect of her care recipient's death. Consequently, as much as she liked her employer and her job, she knew that if she wanted to continue working in Israel, she would have to consider resigning and asking her HR company to find her another care recipient, one who was expected to live longer.

Emily ultimately stayed with the woman for 5 years and left her after securing a job in England. Her employer's family helped her prepare for the job interview and obtain credentials, such as a certificate of integrity from the police. Emily's decision to leave the care recipient and the family was thus related to the opportunity to improve her immigrant status, which happened to involve leaving Israel and moving to a country that provides care workers with a visa that allows them to bring their families with them.

Discussion

Previous research on care workers' experiences of providing end-of-life care has focused on the lack of end-of-life care training and sufficient support in handling their emotional challenges, including various forms and degrees of grief.[4] In contrast, the present study sheds light not only on how these workers felt after the death of their care recipients but also on their experiences and perceptions of the period immediately before death.

During the end-of-life phase, migrant care workers often find themselves not only as the primary caregivers but frequently also as the sole person present with the dying individual. Despite often lacking professional palliative care training, they navigate critical moments and make crucial decisions, experiencing profound feelings of responsibility, fear and isolation. The care workers described having a sense of dedication to their care recipients, even when the latter were perceived as abusive and described how their devotion extended right up to the moment of death. Their approach reflected a deeply-held philosophy of care centred on commitment and embodying what feminist critical social work describes as relational responsibilities.[19]

Our results also show that after the care recipient's death, care workers experience disenfranchised grief – a form of mourning that is not socially recognised or validated. Grief can be disenfranchised in three primary ways: the relationship is not recognised, the loss is not recognised, or the griever is not recognised.[5,41,42] Our study shows that in the case of migrant care workers, this disenfranchised grief is compounded by their status as migrants, often leading them to feel disconnected from the local community. While previous research focused on workers' strategies of coping with the death and the emotional work, as well as the 'grief rules' to which they might conform,[41,42] our study emphasises that the workers' disenfranchised grief is the result of oppression and marginalisation stemming from systemic inequities and power imbalances within society as well as from cultural differences. This perspective highlights how certain groups and individuals experience grief in ways that are unacknowledged, invalidated or rendered invisible due to social, cultural and relational factors.[43] In line with Tsui et al.,[4] who argued that care workers' grief often goes unrecognised because their intimate and long relationships with the deceased are perceived as less important than the relationships between the deceased and their relatives, we claim that the care workers' experience of disenfranchised grief is amplified due to their status as migrants who are not recognised as significant persons in the context of grief over the passing of a loved one.

Our results also show that the death of a care recipient represents more than an emotional loss. It also means a destabilisation and a separation from what was familiar, known and sometimes even loved. The loss is not only that of a relationship with a person with whom they lived and cared for. The workers had to leave their rooms and the houses that functioned as their temporary homes. Quite often, it also means leaving their neighbourhood and town and getting used to a new place. The death of a care recipient, thus, also brings with it considerable uncertainty and insecurity.

Moreover, our results show that immigration policies have a significant impact on migrant care workers' experiences of grief. Because of Israel's immigration policy, workers who have exceeded their 5-year visa and whose care recipient has died have to leave the country. In these cases, the death of the care recipient means having to depart the country. This is a cause for great concern for migrant care workers. Having left their relatives and communities behind in their countries of origin, they pay a heavy personal and familial toll when they migrate and many of them wish to return only after they feel financially settled and secure.[7] To achieve this, they need to stay in Israel for more than 5 years. The grief over the death of their care recipient is then magnified due to the impact it has on their plans.

These findings have far-reaching social consequences, especially for people who are in need of end-of-life care and who struggle to get support and find workers willing to do the job.[7] In his discussion on ageism, Hazan[44] speaks of the 'social death' of older adults, that is, the exclusion of older people and their relegation to places where they are not seen because the presence of older adults reminds younger people of their inevitable death. Perhaps this ageist outlook extends to those who provide care to older people, particularly when these care workers come from marginalised groups – women, people of colour, people from poor countries and migrants. It is expressed through attitudes that diminish the value of the relationship between the older adult and the care worker and the result is disenfranchised grief. The failure to recognise the care workers' experiences, including their grief, becomes one of the mechanisms that exclude both the old and people from underprivileged backgrounds.

The results of this study demonstrate that in spite of power asymmetry in the care triad composed of older adults facing the last stages of their life, their family members and migrant care workers, the well-being and the challenges of all parties involved are interwoven. Neglecting to address the experiences of one of the parties necessarily has an effect on the others while conversely, supporting each party contributes to the others. This approach contributes to the understanding of relational responsibilities.

The core mission of feminist critical social work is to challenge and transform oppressive social structures and power dynamics that perpetuate inequality and marginalisation and to integrate social justice principles into the profession's practical and theoretical realms, challenging the status quo and advocating for transformative change at the individual, community and systemic levels.[45,46,47] In keeping with the feminist critical social work approach, we applied a bottom-up approach to theorising from practical experiences.[48] We aim to raise awareness of challenges and injustices and offer alternative understandings and policies that will support all those involved in their crucial roles. The change should, first and foremost, address and recognise migrant homecare workers' role in society and their important social contributions.

First, HR companies that specialise in the recruitment of migrant homecare workers and their placement in local families should implement measures to provide them with better emotional and psychological support, recognising their unique challenges in end-of-life care situations. This could include establishing support groups, counselling services or specialised training programmes to help care workers cope with both pre-death processes as well as grief and loss. Social workers who are employed in these organisations might play a crucial role in such measures. Second, palliative health care providers, both public and private, should consider homecare workers as an integral part of the caregiving team and train their staff to include the migrant homecare worker in their teamwork. This should be grounded in policy rather than being left to sporadic initiatives, and it might consist of cultural and linguistic training and bridging. Third, as ageing in place and homecare become more prevalent and the support of migrant care workers becomes more crucial to many individuals and families, immigration policies and visa regulations should be reconsidered in light of their impact on migrant care workers' motivations for palliative care.

Limitations and future directions

The present study offers a serious first look at an underexplored yet profoundly important dimension of care work performed by an essential but highly vulnerable labour force. Nevertheless, it has several limitations that should be addressed. One key limitation is that all the participants in the study were from the same country of origin (India) and were employed in the same country (Israel). Our findings and conclusions, therefore, cannot be generalised to homecare workers from other groups and contexts. Another limitation is the fact that almost all the participants were women and thus, the study gave voice mainly to one side of the gender spectrum. Future research would benefit from a larger and more diverse sample of participants employed in various contexts.

Conclusion

The study reinforces previous findings that indicated that the death of care recipients is often a highly significant professional and personal event for care workers and that there is a need for more training and ongoing support for homecare workers engaged in end-of-life care work. Agencies that provide care workers to the employers' families, as well as palliative care organisations that offer services for homecare during the end-of-life phase, should address the homecare workers' roles and experiences. Such steps should not be left to private initiatives but should instead be turned into policy. This policy should consider the fact that these workers are often migrant workers from marginalised groups and should address both the pre-death care phase and the care workers' needs and experiences after death, as well as the impact of local immigration policies on the workers' experiences and considerations.

Declarations

Ethics approval and consent to participate

Ethics approval and consent to participate were made before data curating, IRB of Yezreel Valley Academic College, Confirmation Number: 2019-28YVC EMEK.

Consent for publication

Not applicable.

Author contributions

Daniella Arieli: Conceptualisation; Data curation; Formal analysis; Investigation; Methodology; Project administration; Writing – original draft.

Gila Amitay: Conceptualisation; Formal analysis; Writing – original draft.

Dalit Yassour-Borochowitz: Conceptualisation; Resources; Writing – original draft.

Acknowledgements

None.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Competing interests

The authors declare that there is no conflict of interest.

Availability of data and materials

Not applicable.

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Supplemental material

Supplemental material for this article is available online.

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