

## Article

# The Global Demand for Migrant Care Workers: Drivers and Implications on Migrants' Wellbeing

Shereen Hussein 

Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, Faculty of Public Health and Policy, London WC1E 7HT, UK; shereen.hussein@lshtm.ac.uk

**Abstract:** Background: Demographic changes across the globe create increasing demands for care labour mobility. The contribution of migrant workers to the long-term care (LTC) systems is not confined to the western world or countries that have already completed their ageing transitions; they also play an essential role in maintaining the care systems in countries with emerging ageing populations. Despite the increased demand for LTC services, such jobs remain unattractive with difficult working conditions and insecure prospects in most European countries and are only emerging in the Middle East. This paper explores factors affecting the demand for care mobility, reflecting on the experience of some OECD countries with already aged populations and countries in the Middle East, which are currently transitioning into aged populations. Methods: Conducting a statistical review of key ageing and LTC indicators, combined with a narrative review of relevant literature, the analysis considers the increased demand on migrant care labour. Drawing on a case study of the UK, where the immigration system is being reformed post-Brexit, we utilise In-depth interviews with 27 migrants working in LTC in the UK (2018–2020) to explore impacts on care workers' wellbeing. Results: The findings show that both sets of countries draw on migrant workers as an essential source for LTC workforce supply to maintain and enhance the wellbeing of those receiving care in host societies. Meanwhile, care mobility creates care gaps in home countries, adversely affecting migrant workers' wellbeing. Interview analysis with migrant care workers in the UK showed that such a process adversely affects migrants' material and emotional wellbeing. Conclusion: The ability of migrants to move and work in different countries is shaped by several intersecting systems, including the host country's immigration and welfare regimes. Migrants working in LTC are predominantly women who are usually motivated to work in care due to financial and social needs and usually maintain caring responsibilities across borders. Migrants employ their agency to navigate complex entry systems, settlement, or cross-border mobility to provide LTC in both formal and informal contexts. The implications on migrants' wellbeing are considerable and should be addressed within a context of increased global mobility linked to ageing populations.



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## 1. Introduction

Long-term care (LTC) refers to various services that support individuals with health and care needs over a long or a short period. LTC is organised and provided by a mix of formal and informal support systems [1]. LTC is recognised as vital in ensuring individuals' health and wellbeing in need of support, such as older people or those living with disabilities [2]. Policy developments in many high-income countries have recognised LTC as important in ensuring person-centred support and enhancing the overall independence, wellbeing and quality of life of those receiving services [3]. However, despite the increased awareness of the importance of LTC and its significance, it remains challenging to define and continues to occupy lower status than healthcare. It is considered almost an 'invisible social welfare scheme' in Europe [1]. The lack of recognition of the importance of LTC and its

workforce, combined with funding constraints, leads to unfavourable working conditions in an emotionally taxing sector, rendering it unattractive to many workers across Europe [4]. Furthermore, population ageing transitions observed in most countries are accompanied by shrinking working-age populations with a limited supply of workers within home populations to meet demand. For example, according to the World Bank estimates, the proportion of working-age groups (15–64) out of the total population declined from 67% in 2005 to 64% in 2021 (See: <https://data.worldbank.org/indicator/SP.POP.1564.TO.ZS?locations=EU>; accessed on 14 May 2022; this percentage does not distinguish between national and migrant workers in this age group).

In most European countries, migrant workers, primarily women seeking new economic, social, and professional opportunities, contribute to meeting the escalating care demands. Such flows occur across the globe, between less economically and more economically developed countries, such as from Eastern and Central Europe to Western Europe [5] or from post-colonial nations in the case of the UK or France [6]. For example, nearly 20% of LTC workers in the UK are not British nationals, usually arriving from the Philippines, Eastern Europe, and post-colonial countries such as India and Zimbabwe, while in Italy, migrant home care workers constitute nearly 80% of the entire home care workforce [7,8]. This phenomenon is observed beyond Western Europe. For example, in South East Asia, many countries draw on migrants from neighbouring countries such as China and Taiwan [9], and Indonesia and Singapore [10,11]. In China, while there is no direct policy specific to recruiting migrants to the LTC sector, the Chinese–Philippines bilateral agreement (2018) has facilitated the recruitment of over 300,000 Filipinos, many of whom are employed in the care sector [7].

In ageing transitioning populations, such as in many low- and middle-income countries (LMIC), a surplus of workers is associated with population dividends. However, the LTC systems in most of these settings are still emerging and characterised by informal working practices with minimal employment protection, hindering their ability to attract and retain workers despite these dividends [7,12]. The Middle East and North Africa (MENA) Region includes several countries (between 20–22, depending on different definitions). Most commonly, the region includes countries in North Africa (between Mauritania and Egypt, and Sudan and Djibouti); the Levant region (Syria, Lebanon, Jordan, Iraq, Palestine and West Bank); the Gulf Cooperation Council (GCC) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates) and Yemen. The World Bank also includes Iran as part of the region, and while Turkey sits within Europe and Asia, its proximity to and commonality with the Middle East are notable. The MENA region countries are diverse in their income levels and geography; however, they share important common characteristics, particularly around culture and norms governed by religious and social norms and codes. Furthermore, they are undergoing similar demographic and epidemiological transitions at different speeds. Provisions of care in the MENA regions are primarily within the family or provided through informal domestic support from internal or international migrant women [13].

On the other hand, the demographic trends observed in countries that have already completed their ageing transitions entail reductions in working-age groups with increased demands due to differences in life and healthy life expectancies [13]. As LTC jobs in most European countries are associated with unfavourable working conditions attributed to lack of funding, societal perspective and difficult working conditions, they are considered unattractive to home nationals, especially within competitive labour markets and when unemployment rates are generally low. Migrants tend to have goals that link to their migration journey and their specific employment experience and are thus more likely to accept unfavourable working conditions such as those in the LTC sector [14].

Increases in LTC demand create dynamic mobility channels within and across regions, which are governed by the immigration regimes within the host countries. For example, within Europe, Eastern and Western European countries are at different stages of demographic trends, with relatively more supply of labour-active age groups in the

former than the latter group of countries. The free mobility within the European Union (EU) creates East to West flows of migrants working in LTC, in many cases through circular migration, i.e., migrants who spend regular time across home and host countries [14]. These flow channels are presented beyond Europe, with well-established routes from South and South East Asia (e.g., the Philippines) to Europe. Political and immigration developments, such as Brexit in the UK, are changing the dynamics of some of these flows. Welfare systems dictate the structures, access, and financing of LTC within countries. For example, in Norway, LTC is universally provided and is funded through general taxation with provisions directly from municipalities, with similar working conditions to other public sector occupations. In contrast, the residual welfare system in the UK is means-tested. For eligible individuals, services are commissioned by the local councils within a predominantly independent/for-profit care market with limited influence on contracts and working conditions of workers [15].

There are also strong mobility channels within regions including the far East, Africa and MENA. The increased demand for LTC and the informality of care arrangements increase the demand for migrant labour within these existing structures and potentially create new routes and channels. Hence, migrant workers fill in care demands and deficits within the host population and occur within labour structures that are either completely informal, as is the case in MENA, or within sectors that have structurally unfavourable working conditions and job security and prospects. Migrants working in LTC are thus positioned within contexts likely to challenge their wellbeing due to difficult working conditions combined with limited social networks and demands posed by their caring demands in the host and home countries.

Williams [15] suggests that both care and immigration regimes interact and influence the levels and types of reliance on and contribution of migrant workers to the formal and informal LTC systems. They highlight several indicators, including the extent of LTC provision and how these are distributed within the formal and informal spheres, the relational practices of care policies and the dominant discourses of care cultures. At the same time, immigration regimes manifested through the entry and settlement requirements, coupled with anti-discrimination and equal treatment legislation and implementation, further influence the supply of migrant care workers. Care cultures and the political economy within different countries intersect with care and welfare regimes to further shape the demand, and preferences, for migrant care workers within countries.

Many factors shape the wellbeing of labour migrants, paramount among which are the terms, conditions, and contracts of their jobs, given that work is usually the facilitating mechanism of the mobility of this group. The significance of working conditions to migrant workers' wellbeing is evident in different regions, including Europe and MENA [16,17]. Migrants' personal and social characteristics also influence the wellbeing of individual workers [17]. Literature specific to migrant care workers highlights an increased risk of wellbeing outcomes associated with the emotionally taxing nature of this work and vulnerabilities associated with increased risks of abuse, especially for home and live-in care working in users' homes, which creates blurred boundaries between personal and work spaces [18]. Migrant care workers tend to employ their individual and collective agencies to weigh up the rewards and cost of migration to work in the care sector against other goals such as securing the wellbeing of other members of their families or as an entry point to other opportunities [14,15]. However, there is limited research specific to the wellbeing of migrant care workers. A body of existing literature focusing on labour migrant workers generally identifies employment and working conditions as the main factors shaping migrant workers' wellbeing in addition to their personal and social characteristics [16,19].

This paper has an overarching aim and two objectives. The overarching aim is to highlight the global demand for migrant LTC workers and understand some of the individual costs shouldered by migrants within this process. To achieve this aim, we have two objectives. First, to examine how demographic changes and the existing LTC systems act as determinants for the demand for migrant workers. To explore these relationships, we draw

examples from several OECD countries, which all have completed their ageing transitions but have diverse welfare and immigration regimes. We include some OECD countries: Australia, Canada, Germany, Italy, Japan, Norway, the Republic of Korea (Korea), and the United Kingdom (UK). The choice of these countries was deliberate to provide examples of a diverse group of OECD countries that spans geographical regions and represents different traditional models of care. We also draw on evidence from the published literature on the role of migrant workers in the provision of LTC in countries currently going through their ageing transition; here, we draw evidence from GCC countries. Second, we explore the impact of global care mobility on the potential implications on migrant workers' wellbeing, using a case study of the UK. Employing a case study approach of the United Kingdom, within a context of changing immigration policies and its withdrawal from the EU (Brexit), we utilise 27 qualitative interviews with migrant care workers derived from a study specific to the implication of Brexit on migrant workers (2018–2020).

## 2. Theoretical Framework

Increasing reliance on migrant care workers is derived from several intersecting factors. Prime among these are escalating demands associated with population ageing, welfare regimes, immigration systems and the individual agency of identifying opportunities, weighing risk and rewards and ability to execute decisions.

The demand for a diverse and sizable LTC workforce stems from several determinants. The prime among these is the changing demographic structure in many countries, especially countries that have observed aged populations for several decades, such as Western Europe, North America and Japan [20]. The demographic transitions entail increases in the relative representations of older population groups and shrinkage in the middle age groups, traditionally viewed as the core labour market active groups. These changes in the population structures are derived from historical changes in fertility, mortality and migration trends. The extent of population ageing varies globally but is generally at an advanced stage in more economically developed countries. Yet, the pace of population ageing is incredibly fast in MENA [12]. For example, countries such as Qatar and Saudi Arabia are projected to complete their demographic transition in as little as 10–15 years.

In most OECD and MENA countries, while life expectancy is increasing and healthy life expectancy is also increasing, the latter is not growing as fast as the former. Here, the ageing populations' health status and disease severity are more important than chronological age in determining the demand for LTC and health services [21]. These phenomena present multiple challenges, with increased demands for long-term care and a declining supply of working-age populations, which is predicted to continue along a downward trend, given the observed decline in fertility rates creating further supply gaps.

Migrants working in LTC have traditionally been a flexible source of labour to fill gaps in staffing and are usually recruited from the pool of migrant workers already in the country or through specific migration schemes. Migrant workers are overrepresented in care occupations in several countries, and their share increased faster than in the rest of the economy, even during the economic downturn [22]. The share, composition, and roles of migrant LTC workers differ massively across welfare regimes and contexts: “[d]ifferent care regimes give rise to different types of migrant care work” [23] (p. 142).

Yet, some argue that, despite apparent variations, we can observe convergence in the employment of migrant care workers [15]. For example, migrant workers in the UK are over-represented in the LTC sector. As of 2019–20, foreign nationals represented 17 per cent of an estimated 1.5 million adult LTC jobs in England, compared to only 10 per cent of the total population [23].

LTC systems are considered essential parts of a country's welfare regime; however, they are considerably different globally, including in OECD countries. These differences primarily relate to how LTC is funded and evolved in different countries [24]. A common trend of LTC provision in most OECD countries relates to the progressive policies of marketisation and privatisation [25]. The latter usually refers to increased reliance on the

independent and for-profit sector, where services, when commissioned by the states, tend to be outsourced through a competitive (financial) tendering process. Moreover, it includes an increasing tendency for states to provide cash benefits for those assessed to require care to 'purchase' care services through the open market.

### 3. Materials and Methods

We employed a statistical and literature review of key indicators related to the demand and supply of migrant workers in LTC. We used comparative statistical indicators of ageing, LTC provision and migrants working in LTC, obtained from the OECD library and the World Bank Databank. We used indicators such as age-dependency ratio, life expectancy and duration of ageing transition (or expected ageing transition). We also collated statistics on the contribution of migrants to the LTC sector as much as data were available for different countries. There are limited comparable data on service use and migrant care workers, given scarce accurate data on LTC provision and the specific labour contribution of migrant domestic workers in the MENA region. We relied on published papers and reports on the topic for this region.

The statistical and data review is set within the context of specific LTC policies and immigration regimes, employing a narrative (non-systematic) literature review to present the state of play in the comparative analysis of migrant care work. We used systematic searches and developed a narrative synthesis of the literature. We included literature published in the last 15 years in the English language with a search strategy focusing on migrant care workers, their wellbeing, recruitment strategies and other outcomes. Five electronic databases (EBSCO, OVID, PubMed, CINAHL, PsychINFO) were searched using free text and keyword terms combined with Boolean operators (e.g., migrant\* AND care work\* OR long-term care). Titles were initially screened against eligibility criteria. The study quality was not assessed formally; limitations and potential biases were noted during the extraction process, and 37 full texts were included in the review. We employed a narrative analysis, organising findings into themes using a framework approach [26].

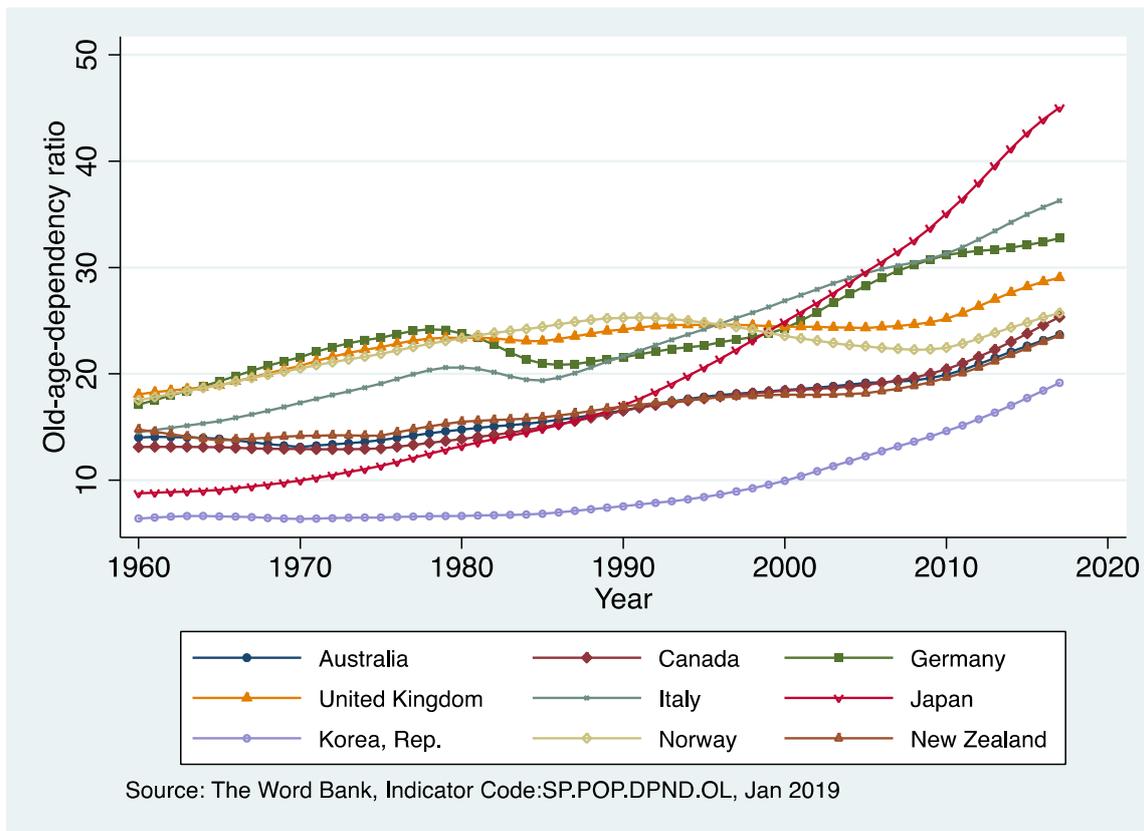
To provide a case study focused on migrants' wellbeing, we utilise 24 in-depth interviews with migrants working in LTC in the UK collected between 2018 and 2020. Ethical permission was obtained from King's College London. Participants were recruited through different channels, including recruitment agencies, social media and snowballing, and interviews were held in-person or online. Participants were briefed on the study objectives, were ensured of their right to withdraw from the study at any stage and gave oral and written informed consent. The interview guide covered questions related to motivation to migrate and migration trajectories, experience in formal care roles in the UK, caring responsibilities in the UK and home countries, the experience of discrimination and racism, the impact of changing immigration policies, especially Brexit, and different aspects of wellbeing, including material, emotional and physical. Participants included 20 women and seven men: 13 were from the EU [Bulgaria, Czech Republic, France, Germany, Hungary, Lithuania, Poland, Spain] and 14 were from non-EU countries [South Africa, Zimbabwe]. All interviews were coded in NVivo12 and analysed using a thematic approach where a coding frame was developed, and common themes were identified, discussed then refined [27]. The analysis presented in this paper focused on exploring issues related to caring deficits created by the mobility of migrant workers and their potential impact on their wellbeing. The first step involved developing a coding frame informed by emerging themes through an iterative refining process of reading and reflections until all data were represented within the selected themes [28].

### 4. Results

#### 4.1. Demographic Changes Shaping LTC Demand and Supply

Analysis of demographic data shows that population ageing has been occurring and will continue in all eight countries reviewed for this paper. Figure 1 shows that the old-age dependency ratio trends have drastically increased since the 1960s, which is already

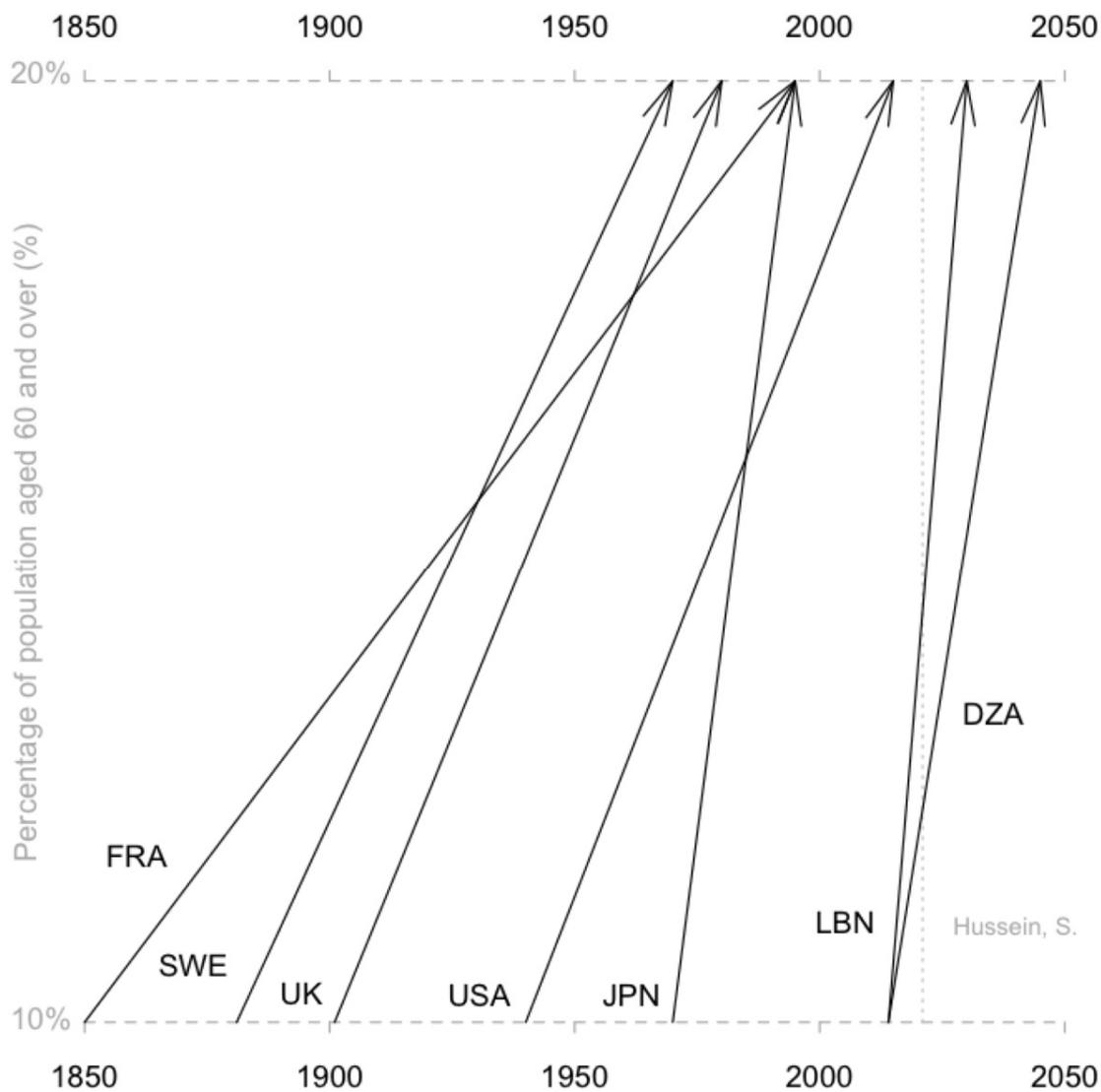
over 30% in Japan, Germany, and Italy. Figure 1 also shows that Korea observes a steep increase in the old-age dependency ratio that started from a lower baseline. If current trends continue, the percentage of the population aged 80 years or over will reach 17% by 2050.



**Figure 1.** Old-age dependency ratio (population aged 65 and over as % of working-age population) (Note: New Zealand was not included in the overall analysis).

Life expectancy at birth has increased steadily since the 1960s, and it now exceeds 80 years for women, and is somewhat lower for men in OECD countries. Increases in life expectancy are further reflected in a steady rise in the proportion of the population aged 80 years or more as a percentage of the total population. Among the eight countries under study, Korea and Japan have the highest proportion of this age cohort, followed by Germany and Italy, while Australia has the lowest proportion.

The MENA region is faced with a swift pace of population ageing with relatively narrow durations for countries to move from ageing populations (where at least 10% of the population are 60 years or more) to aged populations (where at least 20% of the population are 60 years or more) [12,29]. Figure 2 shows that while some European countries, such as France, have taken nearly a century to move from ageing to aged populations, some countries in the MENA region, such as Lebanon and Algeria, are projected to take less than 20 years for the same process. This trend is observed in most MENA countries, despite their political, economic and historical differences [30]. The GCC countries are in a particular position where their ageing transition is expected to start within the next 5–10 years but will take the shortest period to complete [12]. Such a fast pace of change poses significant expectations from policy development, primarily when situated within the context of existing policy challenges associated with economic and political instability, population growth and gender inequalities. Furthermore, with historically high fertility rates, the number of people expected to require some form of LTC support is considered significant.



**Figure 2.** The number of years to move from a percentage of the population aged 60 or more at 10% (ageing population) to 20% (aged population) by different countries (Source, World Bank and United Nations, 11). FRA: France; SWE: Sweden; UK: United Kingdom; USA: United States of America; JPN: Japan; LBN: Lebanon; DZA: Algeria.

#### 4.2. The Contribution of Migrant Workers to LTC Eco-Systems

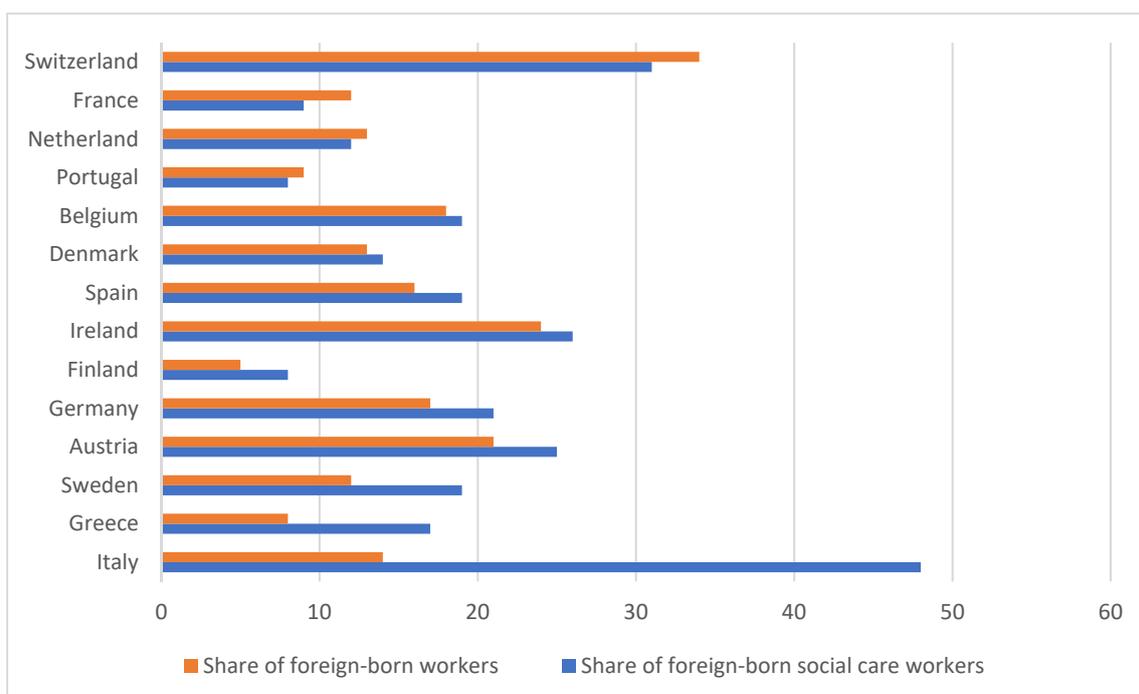
There are significant methodological challenges to comparing the share and role of migrant care workers across countries, including diverse registration and data collection, the grey economy's size and undocumented migration, and settlement and naturalisation rules. It is difficult to obtain statistics on the percentage of migrant workers within informal care settings; one proxy would be to consider the percentage of foreign-born populations within different countries. The statistical indicators' review shows significant differences in the foreign-born population's share across countries depending on historical, geographical, and socio-cultural factors. The foreign-born population is considerably smaller in Japan and Korea than in the other countries reviewed. In Japan, 1.9% of the population were foreign

nationals in 2017 (a record high); the same percentage in Korea in 2016 was 2.3%. It should be noted that very few people acquire citizenship in these countries annually (0.5% in Japan and 1.1% in Korea) (OECD, International Migration Outlook 2018, country profiles).

The International Labour Organisation identifies the Arab states, particularly the Gulf Corporation Council (GCC) countries, as one of the significant global labour migration destination regions, with the proportion of migrant to local workers being amongst the highest in the world. For example, in 2019, there were 35 million international migrants in the GCC countries, accounting for over 10% of all migrants globally (<https://www.un.org/en/development/desa/population/migration/data/estimates2/estimates19.asp>, accessed on 10 April 2022). It is estimated that 3.16 million migrants in the region provide domestic work, with many caring for older and disabled people [31]. The same report highlights that these workers are almost always women and provide live-in care and home help; they usually arrive from African and Asian countries. While there has been some progress in developing laws to protect domestic workers' wages and rights, there is currently a certain level of low compliance with existing regulations and weak enforcement mechanisms in the region [32].

The available data and statistics highlight significant contributions of migrants to LTC provision in OECD and MENA countries. These provisions are happening within diverse structures and levels of (in)formalities within sectors generally characterised by unfavourable working conditions and a lack of career progression opportunities.

Based on the EU Labour Force Survey (2018) (<https://www.oecd-forum.org/posts/shifting-dependencies-migrant-essential-workers-in-the-health-and-social-care-sectors>, accessed on 10 April 2022), the contribution of migrants working in care exceeds the relative representation of all foreign-born workers in most OECD countries (Figure 3). This gap is much broader in some countries; for example, in Italy, nearly 45 per cent of care jobs, while foreign-born workers, in general, are less than 15 per cent of the general population. These figures highlight the over-representation of migrants in care provision, indicating 'shifting responsibilities' of care towards migrants.



**Figure 3.** Migrant workers' share as a percentage of the social care workforce for selected European countries (Source: EU Labour Force Survey 2018).

#### 4.3. Welfare and LTC Regimes

Care regimes across Europe have been traditionally categorised into universal coverage observed in Nordic countries, mixed-economies in Western Europe, family-based in Southern Europe and transitional in Central and Eastern Europe. However, through a progressive process of marketisation and commodification of care, there is a convergence of social welfare models in Europe [32]. This includes increased informality, fragmentation of care provision and increased reliance on migrant workers who might accept challenging working conditions as a means to achieve their primary goal of migration. Therefore, it is argued that one crucial factor in recruiting migrant LTC care workers in many OECD countries is linked to the extent and characteristics of cash-for-care programmes [33].

Published statistics and indicators show that the overall spending on LTC ranges between 0.9% (Italy) and 2.8% (Norway) of the GDP. The most recent OECD estimates of the percentage of people aged 65 or more receiving different forms of LTC for the UK is from 2004, at 6.5% for home and 4.2% for institutional care. The latter is broadly comparable with Norway and Germany; however, the share of those receiving LTC at home is somewhat lower. A more recent study estimated the percentage of home care users at 5.5%; however, using the broader definition of 'home help', the figure was 10.8% [34].

Several countries in the MENA region have been actively reviewing their social development strategies to include elements specific to LTC provision at home and in the community, with a clear emphasis on 'intergenerational solidarity'. For example, the latest Social Development Strategy (2016–2025) of the Sultanate of Oman—a high-income country in the MENA region—highlights the families' role in providing or purchasing care services for older people [13]. Support for LTC is constructed around partial cash benefits based on household income and individual characteristics (age and employment) rather than individual care needs. Similar to the situation in other GCC countries, both policies and levels of community care services are still at the early stages of development, with limited information on the exact level or patterns of use [35]. For example, Turkey developed National Plans for aged care and Dementia Care in 2017 [36], endorsing a 'system of care' approach that is person-centred and enables independent living in the community for as long as possible [37]. Currently, many of these LTC services are provided by the government or the private sector but vary considerably in terms of quality and price. However, the MENA LTC systems rely heavily on family and informal care/domestic arrangements if the immediate kin family is unavailable [12,38]. While there are some emerging policies and strategies specific to LTC, the provision of care remains reliant on the family and informal arrangements, including domestic care provided by migrant workers, with weak standards, training requirements or labour protection for these workers.

#### 4.4. Care Cultures and the Demand for Migrant Care Workers

Family care is preferred and considered better quality in some OECD countries, as in Southern Europe, including Italy [39]. Some argue for the refamiliarisation of care in Europe, where migrant workers become part of the 'family' within which the care discourse takes place [25]. Lyon and Glucksman [40] highlight the importance of national idiosyncrasies concerning seeking migrant care workers and where they are more situated, for example, in nursing homes or home care. They argue that the private employment of migrant care workers sustains the continuity of family care "as an ideal and a practice" in Italy. While in Sweden, for example, the growing role of migrant care workers in informal settings (cash in hand) is rarely discussed because it contradicts the dominant discourse of egalitarianism. In the UK, the discourse around migrant care workers is dominated by 'market value', such as filling gaps in the labour market and allowing family carers to remain in employment [14,41].

Care for older people in the MENA region is primarily provided informally by the family and the community. The lack of formal LTC services, especially institutional care, stems from two roots. First, the ageing population phenomena are relatively new in the region, with limited research and policy attention. Policy developments in the MENA

region mainly focus on poverty reduction, youth unemployment and health care. Second, the drive towards community and home care is shaped by cultural norms associated with caring for older people. The region is characterised by strong family connections and filial obligations, where families and older people prefer to continue living at home in old age. Recent interviews with informal carers in the region indicate that resorting to care homes can be considered a sign of being ‘abandoned’ by the family, despite realising that care in a residential setting might be necessary for older people with specific needs [42].

These preferences for home care, coupled with weak or non-existent formal LTC support mechanisms in many MENA countries, force the reliance on informal care mechanisms. In these contexts, when the immediate families cannot provide LTC, migrant workers employed as domestic helpers tend to contribute considerably to the LTC provision, especially in countries reliant on migrant workers in general, such as the GCC countries [7,31,35,43].

#### *4.5. Immigration Regimes and Migrant Workers’ Agency*

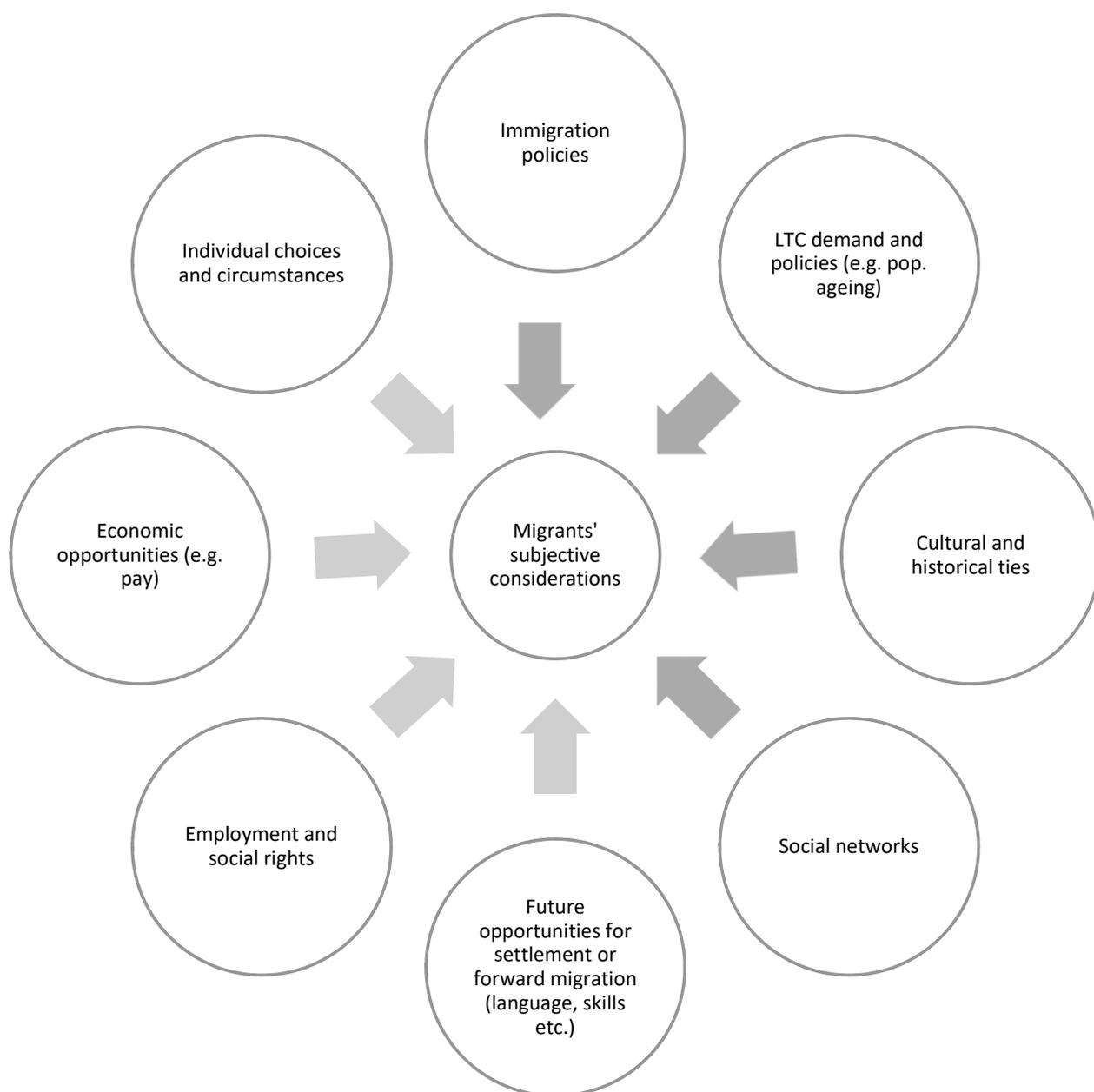
The literature highlights four aspects of legal status as especially important in shaping the living and working conditions of migrant care workers [44]: (1) the availability of and conditions for a temporary work visa program; (2) arrangements allowing specific categories of migrants’ visa-free access to the labour market (i.e., free movement); (3) the existence and extent of regularisation programmes for undocumented migrants/workers; and (4) access to permanent residency status and naturalisation in the host country.

Typical entry channels include: free movement, as in the EU; work visas, especially in GCC countries [31]; and non-work routes, predominantly student/youth and family visas. The relative importance of these hugely varies between countries, even with broadly similar immigration regimes. For example, the EU migration/free movement share differs in Italy, Germany, the UK, and Norway [45].

Within the EU, the freedom of mobility and workers’ ability to move relatively freely across borders creates both opportunities and challenges. Key opportunities relate to the availability of groups of workers seeking employment in new countries. With shortages across Western Europe, migrants are likely to consider working in the LTC sector, especially if they have not yet acquired the necessary qualification recognition or sufficient language skills. On the other hand, some challenges might relate to the LTC sector’s inability to target specific skills or experience or retain workers once they can secure work elsewhere. The recent UK exit from the EU (Brexit) creates further complexities in the supply of migrant care workers to the UK [22,45].

For countries outside the EU, especially in the far East, where immigration policies are stricter and usually target highly skilled professionals, the pool of migrant care workers is reduced to those already in the country, e.g., arriving on family reunification or temporary visas. The latter might create further challenges related to the continuation of care, with implications on service users and the viability of investing in social and skill capital accumulation for fast-moving and transit groups of migrant workers. Furthermore, language and cultural differences create further challenges for migrants seeking employment in countries such as Japan and Korea.

Another critical factor in the migration process is the subjective consideration of structural elements, whose potential impact is a crucial determinant of destination choice. An array of factors shapes migrants’ motivations to migrate and work in LTC. They differ across different groups of migrants, ranging from financial gains to better future opportunities for self or others, with initially difficult conditions considered essential for better long-term outcomes [46]. Furthermore, the relationship between the individual and the host country and perceived accessibility and potential gain can be more important than the specific immigration regime in destination decision making among migrant care workers [47]. The literature also highlights migrant care workers as active agents, where migration interacts between individual and macro-level policies and socio-economic contexts; these dynamics are summarised in Figure 4.



**Figure 4.** Factors affecting migrant care workers' subjective considerations (Adapted from [47], p. 229).

#### 4.6. Migrant Care Workers' Wellbeing

To further understand factors associated with the wellbeing of migrants working in LTC during shifting immigration regimes, we use primary qualitative data from the UK. Employing a thematic analysis of 27 in-depth interviews with migrants working in LTC in the UK, we explore implications for their wellbeing, including potential care gaps in their home countries linked to their move to the UK. For example, unmet care needs of migrants' own families, including their children, parents or other older relatives. This leads to a double burden of care shouldered by migrant care workers. One is through their formal employment in the host countries and another, more informal role, in fulfilling the care needs of their dependents in their home countries. In the sub-sections below, we provide themes that emerged from the analysis of the qualitative interviews to better understand the impact of care work on migrant care workers' wellbeing.

#### 4.6.1. Mobility and Cross-Border Care

For migrants from within the EU, before the implementation of post-Brexit immigration rules in January 2021, it was common to work for a few weeks in the UK and then go back home to provide hands-on care for relatives and elderly parents:

*I get four days off every three weeks, so I've been able to go to France and be with her while she is getting the radiotherapy. The roaming rota [of live-in care] is also good for me in that way. (Irene, woman, EU)*

We also found similar patterns among migrants from outside the UK but only among those with dual EU nationalities who can travel freely across countries. For example, for a participant from South Africa with dual Dutch citizenship, the number of weeks working in the UK is more extended:

*I normally work in the summer months here [in the UK] because it's just obviously warmer and the circumstances are actually much nicer, and then I normally go back to [city in SA] round about autumn months. So, I'll work here, say three months like I am now, and then I'll go back, and then I'll come back again another, say six or twelve weeks, and then I'll go back in November for like four months, so that's like my holiday months and then I'll be on leave for like four months. (Lauren, woman, non-EU)*

Such a state of instability of moving across the globe has adverse effects on the migrant workers' wellbeing:

*When my mum died, you know, I was quite run-down because, you know, three years going backwards and forwards, worrying about my mum, I mean, I had phone calls where I had, you know, a sudden emergency, hospital phone calls and what have you, and had at the same time a deteriorating state of mind with my client, and changing carers, you know, carers who came and didn't want to continue and so forth, it was quite stressful. (Judith, woman, EU)*

#### 4.6.2. Financing and Arranging Care at a Distance

Many migrants working in LTC in the UK have family and caring responsibilities back home, including caring for older parents. Not all can travel across the two countries due to either visa restrictions or financial constraints. They rely, instead, on sending remittances to family back home to care for them. This inability to be there in person has its toll on migrants' wellbeing, as they not only take the burden of remittance, but are also not able to get reassurance or emotional reward directly from the individual they care for, relying on feedback from other relatives in home countries:

*Yeah, and sometimes it worries me, because I can't really do anything about it. I mean, I can't do anything. So, for me the only reassurance is that my brother lives with my mum. So, if something happens, I call my brother and talk to him. And, so, yeah, I'm pleased that there is a family member with her. Since my dad passed away, yeah, they live together. And so it's kind of—it's better for me because I'm away, I'm abroad, and I can't really catch the plane now if something bad happens. (Ausra, woman, EU)*

These transnational care demands further create additional financial burdens on the migrant workers, as other relatives in home countries do not appreciate how difficult it is to save money from care work in the host country:

*Yes, we do, but like I said I am the send money guy. My brother who is older is the one who loves delegating and demanding money. He knows that nowadays it's easy to send money, so he demands, demands, demands. We never have a proper conversation and I avoid him. (Melusi, man, non-EU)*

Other migrant workers felt dissatisfied with their home countries' care available to their older parents. They realised that even when sending remittances, this is not enough to ensure good quality of life for their loved ones:

*But back home, it's really terrible because what they do and how they do it back home is really terrible. When you get there, you'll be weeping for those elders because they are not [cared for properly]. (Linda, woman, non-EU)*

## 5. Discussion

The analysis presented here illustrates a global demand for LTC and migrant care workers that is not limited to high-income countries. Within such structures, migrant workers play a significant role in ensuring and sustaining the wellbeing of those receiving care. Escalating demands for LTC create opportunities for global care mobilities shaped by immigration and welfare regimes [5,6] and the migrants' agency and subjective decision-making process [47]. To a large extent, these dynamics influence the types and nature of migrant care workers' contribution to the host country's LTC system. Table 1 summarises the results of this study. Existing statistical indicators and current evidence from the literature show that for many OECD countries and the MENA region, a combination of forces, including population ageing and demographic and societal changes, result in high shortages in the supply of the LTC workforce. The multiplicity of mobility routes and escalating demands for LTC workers across the globe create new dynamics, where individuals' decision-making processes gain significant weight over immigration and welfare regimes [15,32]. Most OECD countries are converging in their welfare regimes, with LTC markets taking a prominent position in shaping the demand and facilitating higher levels of migrant workers' contributions. However, these occur within sectors characterised by poor regulations, difficult working conditions and increased vulnerabilities of workers to potential labour and emotional exploitation [48].

**Table 1.** Summary of findings and differences across the selected OECD and MENA countries.

Theme	OECD Countries	MENA Region
Demographic changes shaping LTC demand and supply	Trends of ageing populations since mid 19th century. High ageing indicators in Japan, Italy and Germany. Korea observed the most significant change.	A fast-paced change in population ageing is observed in all countries in the region. GCC countries, in particular, face a very rapid transition to aged populations in the next 20 years.
The contribution of migrant workers to LTC Eco-Systems	Significant contribution through formal and informal routes. The contribution is considerably higher in European countries, e.g., Italy, Switzerland and Ireland, then the far East, e.g., Japan and Korea.	Difficult to establish exact contributions. Evidence of high level of care provision within domestic settings mainly provided by migrant women from Asia and Africa.
Welfare and LTC Regimes	Well-established care regimes that were traditionally divergent. A progressive marketisation agenda have led to a convergence of most regimes towards a mixed economy of care markets. LTC spendings as a percentage of GDP varies from 0.8% to 2.8%.	Emerging ageing-policy landscape. Focus on the role of the families and communities. Weak formal LTC sector.
Care Cultures and the demand for migrant care workers	Movement toward refamiliarisation of care. Migrants play a significant role in the provision of care both formally and informally. Personalisation policies, e.g., cash-for-care, facilitate the recruitment of migrant LTC workers.	LTC primarily provided informally and by the family. Competing policy priorities. Domestic work includes LTC. Fragmented formal LTC services. Stigma related to institutional LTC.

Table 1. Cont.

Theme	OECD Countries	MENA Region
Immigration regimes and migrant workers' agency	Immigration routes primarily through free mobility (EU), bilateral agreements (Asia), family reunion or post-colonial ties (Europe). Evidence of migrants' agency in destination choice.	Immigration routes mainly through temporary work visa schemes. Limited evidence on migrants' decision process beyond financial needs.
Migrant Care Workers' Wellbeing	Evidence of care burden and care gaps in home countries. Implications on migrants' material and emotional wellbeing. Differential impact linked to ability and access to travel between home and host country; remittance and ease of arranging care at a distance.	

In some countries, particularly in the MENA region, the lack of formal LTC systems and informalities of care provision extends the tasks of existing domestic workers' duties to include LTC provision without formal training or labour protection. Reduced employment protection and poor working conditions adversely impact LTC workers [49]. Migrants working in LTC constitute an essential element of the supply of both the formal and informal LTC workforce; however, the level and context of their contribution vary widely across countries. Furthermore, the disproportionate higher representation of migrants working in LTC compared to that within the general population may indicate the unattractiveness of the LTC working conditions to the home population and its reliance on individuals in dire need of jobs, such as migrants.

Immigration regimes interact with welfare systems and structures to shape, to a large extent, the types and nature of migrant care workers' contribution to the host country's LTC system. The reliance on migrant LTC workers and how formally they are integrated within the sector differ across countries and regions. Their recognised contributions are impacted not only by the host country's welfare system and how it is organised and funded, but also by several factors and policy dynamics. The host countries' immigration policies and the availability of informal care are prominent among the latter. The agency of migrants is also an essential factor to consider in how decisions around the migratory process and work choices are made [47]. The reviews and analyses show that migrant care workers range across a spectrum of extending informal family care, with considerable input from migrant workers that is less regulated, e.g., in Italy and GCC countries, to a more controlled contribution specific to highly regulated programmes, e.g., in Germany. In some countries, migrants enter the LTC sector through various routes; none of them might be initially designed for their involvement, resulting in high uncertainty about their sustainability as a critical source of the care workforce.

It is argued that migrant care workers are critical in ensuring the host society's most vulnerable wellbeing through their contribution to the formal and informal LTC sphere. At the same time, their wellbeing is adversely impacted due to unfavourable sectoral conditions, reduced rights and opportunities dictated by immigration regimes, institutional racism and lack of support in host countries. Migrant LTC workers, in the majority, are women, and these global flows bring significant consequences far beyond simply substituting the LTC workforce in the receiving countries. Such implications vary from the care chains created when migrant women leave behind their caring responsibilities to integrate into the receiving countries, with a spectrum of issues questioning the sustainability of such supply [6,50]. Some of the topics debated in the literature include, but are by no means limited to, the opportunity cost of such flows on individuals and societies, the career progression of migrant workers who usually hold professional training and qualifications, fairness and societal inclusion and suitability and quality of care, among others [51].

The analysis of primary qualitative interview data from the UK shows that, while the current dynamics of ageing and LTC create opportunities for migrant workers' mobility and their ability to secure jobs in higher-income countries, these come with certain costs paid by migrant workers. These are associated with implications for their wellbeing and the difficult working conditions of the LTC sector combined with new care gaps in home countries created through mobility. The analysis found that migrant workers go through a considerable process of negotiating care arrangements in their home country. Such arrangements include the physical provision of care in the UK and across borders in their home countries by employing a detailed working rota. These arrangements were particularly relevant to EU migrants and non-EU migrants who can travel freely, for example, those from South Africa with Dutch passports. Others, who cannot travel freely and frequently due to financial or visa constraints, usually tend to finance and organise care provisions in the home country. The impact on the wellbeing of migrant care workers was found to be significant in both types of arrangements.

Migrant LTC workers are often women who have caring responsibilities for younger and older members of their families. In their attempts to address care gaps in their home countries, the burdens on their material and emotional wellbeing significantly increase. The continued demand on individual migrant workers to provide, or organise and fund, alternative care in their home countries further compromise their wellbeing. Receiving countries need to acknowledge the weak position and ability of migrants, in general, and migrant LTC workers in particular, to negotiate better working conditions for themselves. Their specific profile and the multiple demands placed on them from home and receiving countries involving emotional resources and resilience have significant implications on their wellbeing and quality of life. The literature on migrant wellbeing is limited, and that on migrant LTC workers is sparse. This study adds an essential contribution to this knowledge gap. While most OECD and GCC countries rely on migrants to work in LTC, there are no specific measures or interventions to mitigate expected adverse implications on migrants' wellbeing [48]. To maintain a sustainable contribution of migrant workers, increased efforts are needed to address these burdens.

The findings of this study have several policy implications. For OECD countries, the demand for LTC continues to escalate, and with shrinking working-age groups, the reliance on migrant workers will continue. LTC workforce planning should be a priority area, with strategies focusing on enhancing LTC jobs and working conditions to attract home and migrant workers, realising the competitive landscape different countries operate within. For example, Western European countries continue to draw on migrants from Eastern and Central Europe, where individuals employ their subjective decision process to choose their destination. Similarly, countries in the far East compete for labour mobility from neighbouring countries such as the Philippines. Implementing interventions to support the wellbeing of LTC workers, including migrants, will improve retention and reduce overall costs associated with recruitment and retraining. For countries in the MENA region, the emerging trends of ageing transitions call for rapid strategic developments. Prime among these is establishing regulated LTC markets where the quality of services and employment contracts should be ensured.

**Limitations:** While this study attempted to cover a broad range of evidence, including published literature, statistical data and qualitative interviews, some elements are still missing. In particular, there is limited accurate data on the contribution of migrants to LTC provision in the MENA region, and there are no comparative qualitative studies on migrant LTC workers in the region.

The demand for migrant care workers is global and not restricted to high-income countries or those at a later stage of population ageing. The flow of workers, particularly women, continues to be significant in maintaining LTC systems and the wellbeing of those using such services in many countries. Migrant care workers, thus, positively and significantly contribute to the enhancement and sustainability of the wellbeing of those in need of LTC in host countries. Simultaneously, these global mobilities create care gaps

in home countries, with increased pressure on the same workers to either provide cross-border care or organise care at a distance, while compromising their wellbeing policies. Structures should be implemented in receiving countries to ensure the sustainability of migrant workers' wellbeing to ensure continuity of care and to meet current and future care demands.

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