Global care chains: a state-of-the-art review and future directions in care transnationalization research

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Abstract *This article provides a state-of-the-art review and sympathetic critique of global care chain (GCC) analysis, focusing on its contributions to a sustained research agenda on care transnationalization. GCC analysis has opened up theoretical perspectives and discursive spaces for the sophisticated understandings of globalization processes. Rooted in global network methodology and cognizant of the grounded, textured and embodied nature of care transnationalization, GCC analysis has significantly contributed to better understandings of the socio-spatial dimensions of diverse forms of care provision worldwide and the identification of transnational political and policy responses. This research agenda is far from exhausted and future research could productively address the following critiques and the conceptual and theoretical issues to which they give rise: first, that GCC research may reinforce care work as women's work; second, that it privileges some aspects of care transnationalization over others; and, third, that GCC analysis renaturalizes the nation-state. The discussion outlines the implications of these issues for future directions in care transnationalization research.*

Keywords GLOBAL CARE CHAINS, CARE WORK, MIGRATION, NETWORK METHODOLOGY, GLOBAL NETWORKS, CARE TRANSNATIONALIZATION

Thanh-Dam Truong cogently encapsulated much of what was missing from the burgeoning globalization studies literature when she argued that '[no] production system operates without a reproduction system and it should not be surprising that the globalisation of production is accompanied by its intimate "Other" i.e. reproduction' (Truong 1996: 47). Supporting this conceptual innovation was evidence of the significant presence of migrant women working in the expanding domestic and sexual services economies in Europe and Asia. Truong argued that these service economies are organized on a *transnational* scale rather than on a purely national one and that research and campaign efforts needed to be directed accordingly. Her intervention

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helped catalyse an international research agenda mapping the causes, dynamics and consequences of the globalization of paid and unpaid reproductive labour. At the core of this agenda lies a focus on care. As a key dimension of reproductive labour,[1] care occupies an important position in social policy because of what its social organization reveals about the nature of social relations and practices as well as of welfare formations more widely. Within this context the global care chain (GCC) analytical framework (Connell 2008; Ehrenreich and Hochschild 2002; Hochschild 2000; Isaksen et al. 2008; Orozco 2009a, 2009b; Parreñas 2001, 2005; UNFPA 2006; Walton-Roberts this issue; Yeates 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2009c) has emerged to occupy centre stage in efforts to document and understand the global relations of welfare and care.

This article provides a state-of-the art review and sympathetic critique of GCC analysis. In it I survey the development and applications of the GCC construct, assess contributions of GCC analysis to globalist social research and policy analysis, and identify key issues to address in future. I have organized the discussion as follows. In the second section, I review the key elements of the GCC construct and chart its development into an expanded analytical framework. Emphasized here are GCCs' grounding in network analysis and the approach to care adopted, including the conceptualization of care work as a major form of reproductive labour. The discussion then turns, in the third section, to assess the contributions of GCC analysis to understanding forms, dynamics and consequences of care transnationalization. I argue that GCCs have: opened up discursive spaces for the flourishing of sophisticated understandings of globalization processes as grounded, textured and embodied; contributed to better understandings of the socio-spatial dimensions of diverse forms of care provision globally; and generated analyses of the global economy, including the identification of political responses that transcend nation-states. However, to progress this research field, much more work remains to be undertaken. Accordingly, in the fourth section I outline a number of key issues to be addressed. In summary, these are as follows. First, while GCC research focuses political attention on female migrants it may reinforce the perception that care work is women's work. Second, GCC research tends to privilege certain occupations, forms and dynamics of care transnationalization at the expense of others. Third, GCC research may inadvertently renaturalize the nation-state by focusing only on care migration that transcends international state borders. The implications of these issues for future GCC research are identified and briefly outlined. The article concludes by summarizing the main arguments presented in it and arguing for extended applications of GCC analysis and, by extension, network methodology in the context of care transnationalization research and policy analysis.

Global care chains: elements of analysis

At its most basic, the GCC refers to a series of 'personal links between people across the globe based on the paid or unpaid work of caring' (Hochschild 2000: 131). This definition arose out of Arlie Hochschild's substantive concern with transfers of

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'motherly' care through the Filipino–US nanny trade and the extra-territorial dimensions and impacts of what initially appear to be national struggles for gender equality at home and at work. Hochschild's depiction of the GCC viewed it as driven by a woman living in a rich country (the USA) with one or more dependent children who finds herself unable to fulfil her 'domestic duties' without working a 'second shift'. To free herself from this additional labour, she recruits another woman to do it on her behalf. This other women is drawn from a poorer household, increasingly, it is suggested, from abroad (Philippines). By migrating to take up paid domestic labour the migrant woman finds herself unable to discharge her own 'domestic duties' because she is geographically distant from her children and her home, creating a need for someone else to do so. That person – often another woman – is drawn from an even poorer household in the sending country or she may be a member of the migrant woman's own family. As we go 'down' the chain the value ascribed to the labour decreases and often becomes unpaid at the end of the chain, where an older daughter may substitute for her mother in providing unpaid care for her younger siblings (Yeates 2005a: 2–3).

The GCC construct as proposed by Hochschild drew loosely on global commodity chain (GCommC) analysis (Yeates 2004a, 2009a). GCommC analysis is grounded in network methodology in its focus on social interactions between various actors in networks and their structural outcomes (Dicken et al. 2001: 91) and in *global* social network analysis by virtue of its focus on organizational forms that regularly transcend state borders, connect more than one country over long distances and are multicentred (Holton 2008: 43). The tenets of GCommC analysis in the GCC construct are evidenced in the depiction of geographically dispersed but coordinated families linked together by the provision and consumption of care, with each stage in the production of care adding emotional and economic value. In GCCs involving nannies, family linkages result from household outsourcing and internationalization strategies at both ends of the chain. Outsourcing mobilizes care labour supply through kinship (and non-kinship) networks, as well as through the market mechanism, while internationalization (in the case of households in sending countries) takes the form of emigration by the mother to take up care work overseas, or (in the case of households in destination countries) the recruitment of overseas labour. These processes may involve state and non-state intermediaries operating within and across national territories. These strategies produce an international network of families comprised of transnational households as well as different households linked through the employment nexus (Yeates 2005a: 3).

GCCs vary in terms of the length of the chain, the socio-geographical spread of the links and the intensity of their connective strength, but essentially establish global relations of social inequality in two ways. First, they forge links between adult service providers and service recipients, as well as between their children, based on social relations of inequality. Thus, predominantly female adults from poorer countries serve adults and children in rich (destination) countries. Second, these networks are a key mechanism by which care resources are extracted from poorer countries and transferred to richer ones. The costs of these transfers are predominantly borne by migrant

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mothers and their children who experience intense loss and deprivation at long-term separation, while the benefits are predominantly enjoyed by employer parents, who are relieved from conflicts relating to family–work balance and the sexual division of domestic labour, and by their children who are the object of 'surplus love'. GCCs also have wider social impacts. The nanny trade enables destination countries to postpone egalitarian systems of public childcare, and it enables source countries to generate foreign revenue and export social conflict while also depriving them of strategic resources for development (Hochschild 2000; Yeates 2004a, 2005b).

In developing the GCC construct, Nicola Yeates (2004a) more firmly rooted it more firmly in GCommC analysis and network methodology. Since GCommC analysis developed in the context of manufacturing, conceptual and theoretical modifications were needed to take account of the specificities of human (and care) services.[2] For the purpose of the present discussion it is important simply to note that Yeates retained the materialist focus of GCommCs and key analytical components (structure of inputs and outputs, territoriality and governance), but introduced modifications to emphasize transnational labour networks (rather than interfirm relations) and a labourist approach to care that recognized both the physical ('caring for') and emotional ('caring about') dimensions of care work.[3] Yeates's conceptual and theoretical formulation encompassed a wider range of non-material inputs, outputs and impacts than even feminist approaches to GCommCs (Dunaway 2001) had previously recognized. Emphasizing the complex, multifaceted care production processes that involve multiple actors and settings and unfold over time, Yeates argued:

> In global commodity chains these processing elements are presented as clearly defined stages organised sequentially; in global care chains, these stages are not necessarily confined to the care chain or organised sequentially within it. For example, the process of skills acquisition and development starts from childhood and continues throughout the carer's working life in a variety of institutional contexts and informal settings. This process of skill acquisition varies depending on the skill level that is applied to the job. Thus, while some work is considered 'natural', requiring no special job training, other care work involves learning 'on the job'; other care services, such as nursing, have a hierarchy of training regimes, varying from no training to on the job training to college/university training, depending on the labour hierarchy within the service. These skills can be acquired or learned from co-workers on the job or acquired through state-sponsored education or purchased from commercial suppliers.
>
> (Yeates 2009a: 59–60)

Of note here is the difficulty in identifying tangible outputs. In some cases this is more straightforward (a domestic worker's output might be a clean house, or for a nurse the recovery of a sick patient) but the relational and often intangible nature of care services means outputs cannot always be identified let alone have their value

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calculated. Indeed, this is one difficulty limiting the commodification of care; as corporate nursing care providers have discovered, it is difficult to bill customers for 'time to listen to somebody's story, time to hold their hand, time to comfort somebody who is feeling troubled' (Folbre 2002 citing Eaton 1996: 7).

Finally, whereas GCommC analysis envisaged the state as part of 'external governance' (Gereffi and Korzeniewicz 1994), Yeates envisaged it as integral to GCCs with the state playing a key role at all stages in the production and consumption of care services as well as in the governance of interactions between multiple actors in the care chain. In the case of global nursing care chains (Yeates 2009a), the state plays a formative role in their development, whether in overseas nurse recruitment, the development of stricter country and sector access conditions, or the creation of a state bureaucracy to encourage and manage nursing care labour export as part of economic development efforts. Yeates argued that the state is paramount in ensuring that 'local' nursing education systems adhere to global (namely Western) standards, with countries that fail adequately to regulate nursing education programmes being restricted to poorer and regional markets. Thus, the state (and state policy) is a key element explaining the territoriality – spread and length – of a care labour network, together with the distribution of benefits, risks and costs within it (Yeates 2009c. See also Choy 2003; Ishi 1987).

Alongside this work of embedding human (care) services production more firmly in network analysis, Yeates broadened the scope of enquiry to capture the multiplicities of care-related migration and to reflect diverse occupational, sectorial and organizational settings in which migrants work. Migrant care workers are by no means limited to providing social care in individualized household settings in rich Western countries (Yeates 2004a). Cleaning, cooking, laundry work and childcare also take place in institutional settings such as nurseries, hospitals, care homes, schools, offices and hotels. Similarly, labour market factors or women in rich receiving countries do not drive all GCCs involving domestic work; the maintenance of lifestyle and social status are of importance here. Women in the Middle East, for example, do not have high labour market participation even though this region, in particular the Arab Gulf countries, was one of the first major targets for migrant care labour in the second half of the twentieth century (Silvey 2004). Finally, migrant care workers are present across many occupations/subsectors other than childcare and domestic work. These include, for example, care of the elderly, healthcare, social work and education, all of which are carried out in institutional as well as household settings and in public, commercial and community contexts (Yeates 2004a, 2004b, 2009a).

Broadening the scope of enquiry in these ways extends the capacity of GCC analysis to capture diversity in the care services sector and the complex positioning of migrants therein. It reflects better the spectrum of skill involved in care labour provision and captures the growth in skilled migration that has been a feature of the contemporary period (Kofman 2005) as well as in previous periods (Yeates 2009b). Relatedly, it captures the spectrum of labour remuneration and working conditions and of capital-labour input intensity, organization and regulation within the sector. The confluence of these differences can be mapped onto a continuum. At one end of

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this continuum is capital-intensive care involving corporate entities providing personal health and social care services (usually) in institutional settings (such as hospitals, nursing homes, nurseries and certain domestic and house care services), relying on skilled, professional labour and operating within a highly regulated institutional environment governing funding, regulation and conditions of service provision. At the other end of the continuum is care provision involving low start up and market entry costs. This (often low-tech) care provision requires constant attention, operates on a more atomized and informal basis (through individual recruitment strategies and family and friendship networks), exhibits a greater preponderance of unskilled, unqualified and poorly paid labour, and has low levels of regulation with precarious (often illegal) work (Yeates 2004a: 381–2).

Yeates's presentation of these divisions does not suggest that there is a strict correlation between these various axes (after all, corporatization has not occurred only in areas requiring capital-intensive inputs and professional labour). Rather, there is often an association between them: examples clustering at the extreme end of one continuum will also tend to be at the end of another continuum. For example, the sex trade tends to be unregulated, labour intensive, unskilled and atomized. The professional nursing trade, however, involves skilled labour, is regulated and corporatized and supplies capital-intensive operations (Yeates 2004a). The organizational features of different parts of the care sector have implications for labour migration in terms of, for example, recruitment to and regulation of access to the sector, the conditions under which care work is carried out, the nature of labour and wider social rights including the extent to which they are enforced. These features impact upon care transnationalization in terms of what drives it, how it proceeds, who bears its risks and costs, and how the benefits are distributed.

This consideration of diversity within the care services sector brings in a wider range of state and non-state actors involved together with the varied economic, political and cultural logics of care migration (and the governance thereof). To illustrate this point, consider the involvement of the voluntary sector in global care migration. This brings a focus on transnational actors such as international aid and development organizations and the paid as well as unpaid care work provided by their staff for local populations. It brings in institutions with an established historical presence in global care migration, such as the Catholic Church. Moreover, it complicates analyses of governance given that the Catholic Church operates (partially) outside the state frameworks that govern migration and care provision. These counter dynamics of global care migration provide a welcome focus on developed to developing country migration, and on migrants' motivations (especially religious ones) that cannot be wholly understood within an economic framework, however broadly conceived. Finally, the inclusion of religious migrant care workers adds a new dimension to care – namely spiritual care. Spiritual care addresses the metaphysical dimensions of existence and the well-being of the other; it is distinct from emotional and physical care, even if it is provided through a range of social, health and educational services offered in secular and religious settings (Yeates 2009a, 2009b).

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This broader conception of care and the care services sector also facilitates recognition of the diversity of migrants and their marital, parental and familial circumstances. Not all migrant care workers are mothers with dependent children who subcontract their childcare labour while abroad. Some succeed, through family reunification and other means, in bringing their spouses and children to live with them. Others have never been, or are not currently, married, and do not have dependent children, but have care obligations towards other family member(s) (Parreñas 2001). This expanded conception of care practices counters the heterosexism evident in the initial GCC construct (Manalansan 2004) and recognizes the heterogeneity of transnational families (Yeates 2009a). It also opens up questions about how international migration mediates responsibilities, expectations and practices of care in immediate and wider family/kin networks, and how these change over time and between generations. What are the other forms of reward for remitting (such as the promise of future security and care and increased social status)? To what extent do migrants respond to the expectations and demands of family back home regarding care provision? And how do they balance these demands with those from their families in the new country (Bryceson and Vuorela 2002; Yeates 2004a, 2009a)?

Finally, broadening the scope of GCC analysis adds a necessary historical dimension. The decidedly contemporary emphasis of the recent literature on migrant domestic workers misses important historical precedents to internationalized outsourcing practices. Historical studies variously highlight how migrant domestic workers linked rural to urban economies as well as the economies of sending and destination countries (Katzman 1978; Yeates 2009a). They also show the extent of nursing transnationalization under previous periods of globalization (including how this entwined with religious transnationalism) (Choy 2003; Yeates 2009a) and the extent to which transnational families have long been integral to slave, colonial and settler societies (Bryceson and Vuorela 2002; Delaney 2005; Hondagneu-Sotelo and Avila 1997; Plaza 2000).

This historicization is necessary 'if the concern is not just to map the spread and structure of these chains but also to understand their transformation over time and the confluence of factors bearing on that transformation' (Yeates 2004a: 380). In the case of nursing, the direction of movements – from developing to developed, from poorer to richer, from rich to richer – has remained constant, but nursing chains have lengthened and multilateralized. Thus, Indian nurses, who originally went to the Gulf States only, increasingly see employment there as a stepping stone to, for example, Ireland or Britain, which again may only be a staging post to their eventual destination in the USA. Colonial ties are often significant in understanding why GCCs have emerged and the form in which they developed. Although colonial ties do not explain all nursing chains (for example, from the Philippines to Libya and Saudi Arabia), there is nevertheless an association between labour-exporting state strategies and the level of economic development attained, which is often closely connected with a country's colonial history (see Yeates 2009a, especially Chapter 4). Colonial (and other historical and associated) ties may be lessening in importance 'as destination countries become more utilitarian in encouraging migration primarily on the basis of economic requirements' (Bach 2003: 9).

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Grounding, embodying and texturing care transnationalization

The development of GCC analysis in the ways outlined above has generated discursive spaces for sophisticated understandings of care transnationalization (and globalization more generally) as grounded, embodied and textured. GCCs are *grounded* in a materialist, relational approach to the care economy emphasizing the (re)production of a web of international socioeconomic relationships (Dicken et al. 2001: 106). This approach is traceable to GCCs' roots in network methodology generally and global network analysis specifically. These analytical frameworks focus on tangible mechanisms, structural outcomes and empirical impacts not offered by other perspectives on care transnationalization.[4] The focus on border-spanning networks avoids the fundamental pitfalls of '"atomistic description[s]" of activities of individual actors' (Dicken et al. 2001: 91) which fail to account for social structures and processes propelling and sustaining care labour migration. It also avoids the limitations of 'meta-individual imaginations of "deep" structures' (Dicken et al. 2001: 91) that read care migrations off macro-structuralist 'logics of capitalism' scripts of the global system. The analytical focus on global networks keeps sight of structural understandings of global power relations; the emphasis on social interactions between defined actors foregrounds human agency in the formation of care networks (cf. Dicken et al. 2001; Holton 2008) As such, it keeps in clear sight an understanding of care transnationalization as an embodied process shaped by and impacting upon human beings in tangible ways.

This grounded and embodied approach to care transnationalization has brought multiple *textures* of care labour migration to the foreground. From the early simplistic portrayal of GCCs has emerged a rich appreciation of diverse historical contexts and antecedents, intra- and cross-sectoral dynamics, and wider sociocultural, economic and political considerations variously shaping demand care labour migration. This has, in turn, facilitated recognition of marked differences between GCCs[5] and with it the prospect, though not yet the reality, of comparative GCC analysis.

With the injection of a socio-geographic analysis into care has come recognition of the crucial importance of locality in care transnationalization. Territoriality is expressed in regional as well as global flows, and it captures uneven development and geo-inequalities in power and wealth. Thus, GCCs involving domestic workers (Ehrenreich and Hochschild 2003; Parreñas 2001), nurses (Ishi 1987; Kingma 2006; Yeates 2009a) and religious workers (Yeates 2009a) all reflect the geo-positions of countries of origin and destination in the world system past and present. The characteristics of GCCs involving care workers migrating from and to different places vary. Thus, GCCs involving migration from a poorer EU country to a richer one differ from those involving migration from poorer Asian country to a richer one, or from a richer African one to a North American one. These differences emanate from the effects of intersecting health, welfare, trade, aid, development, immigration and emigration regimes in source and destination countries that are, in turn, part and parcel of the global political economy of power, development and migration.

Intersecting social divisions of gender, class, age/ generation, 'race' and ethnicity

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also texture GCCs. Most work has focused on gender (or more precisely, women) in GCCs, but Manalansan (2004) points to the intersection of gender and sexuality in the presence of gay Filipino men as foreign care workers, and male doctors in the Philippines retraining as nurses to gain access to the USA and Europe. Yeates (2009a) points to the importance of social class, with many of the Filipino and Indian nurses in her study seeking through the higher wages they could earn from work abroad the means of attaining, or continuing to maintain, middle-class status; gender and class were also found to intersect in access to initial nurse training. These intersections take on an intergenerational dimension as migrant remittances fund the reproduction of migrant labour: thus, there is an expectation that migrant nurses will repay their relatives for financing their education/training by financing professional training for the next generation (Yeates 2009a). Finally, Walton-Roberts (this issue), in her study of nursing care chains in South India, comprehensively highlights how gender, class and sexuality intersect, arguing that 'the discursive context of linking impurity to assumed sexual behaviour undermines the social mobility female nurses gain through migration' (Walton-Roberts 2012: 190).

'Race' and ethnicity are crucial in this context. Many employers express a preference for care workers from certain countries whom they believe possess certain behavioural, cultural, linguistic or religious traits thought to bear on the quality of the service provided. Thus, Maher (2003) has shown that a discourse that sees imported Mexican maids and Peruvian nannies as, respectively, 'natural mothers' and 'submissive' workers, echoing narratives about the 'nimble fingers' of female Asian electronics workers, underpins the market for foreign domestic workers in California and Chile. While these discourses legitimate the segmented labour market, they also indicate the special domestic and nurturing skills that employers often hope to extract from these workers. In nursing chains, issues of 'race' are also concretized in working conditions. In Saudi Arabia, for example, a racialized hierarchy of nurses has been reported, with Filipina nurses tending to work as general nurses, while European nurses are more specialized and receive higher wages than Asian ones even if they are less qualified than them (Yeates 2009a). Western countries are not, of course, immune from institutionalized racism. Migrant nurses routinely experience downward occupational mobility, variously working as care workers in residential care homes or in the hospital laundry and cleaning service, or channelled into low-skilled, low-paid menial and non-career nursing grades in unpopular specialties and positions that are not concomitant with their skills and aspirations (Bach 2003). We also need to note the significance of religion in this context. Guevarra (2010), for example, reports that, due to cultural restrictions on women, employment brokers in the Philippines recruit women from the predominantly Muslim southern Philippines to fill what Catholic Filipinos regard as undesirable vacancies in the Middle East. The material implications of this cultural economy are significant: Muslim Filipinos working in the Middle East earn less than Catholic Filipinos earn working in (for example) the UK or USA.

GCC research has opened up conceptual space for globalist ethical and policy analyses to emerge. The concern of GCCs with tangible mechanisms that (re)create relations of interdependence emphasizes issues of vulnerability and affectedness. This

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applies at the psycho-social level, as in the vulnerabilities of migrants and their children (Hochschild 2000; Parreñas 2005), or at the labour level, as in the exploitative labour and social practices and human rights breaches committed by employers (Bach 2003; Yeates 2006). It also applies at the level of wider social development, as in contributions of remittances to social welfare, economic enterprise or the balance of accounts, or the collapse of health care systems and the numbers of extra deaths occurring each year due to a shortage of skilled, qualified labour (Awases et al. 2004; Connell 2008). The emphasis on tangible mechanisms enables the identification of critical linkages and points of intervention to help alter the distribution of risks, costs, benefits and profits. In this context, several questions arise. One question is how one can better share the welfare gain by destination countries arising from care migration across the network. Currently, a share of the welfare gain stays in the destination country (care recipients, recruitment agencies and employers), some goes to the nurse, and the remainder accrues to the country of origin (in emigration fees and remittances). A second question is how to address the burden of risks, costs and exploitation currently falling on migrants and developing countries. Both these questions relate to the third question, namely how to regulate the international trade in care migration in the interests of public health and welfare.

Various policy and political responses to address care transnationalization have emerged. These range from regulating recruitment (codes of practice), to restricting emigration (bonding and retention schemes) to planned self-sufficiency (increasing the production and retention of care workers and reducing reliance on overseas labour), to altering the economics of care migration (obliging recruiters to pay the full cost of migrants' education and training to the source country). These responses tend to assume that competing state, commercial, professional, labour and household interests can be reconciled. A GCC perspective alerts us to the danger of such assumptions. Looking across the care chain, we need to ask how the need for migrant care workers for the elderly in European and North American countries weighs against the need for nurses to provide primary healthcare in developing countries. And how do the wishes of the individual (and his/her family) to pursue a profitable career overseas measure up against the loss of substantial public investment needed to produce skilled, qualified care workers, or against labour (and other) interests that may seek to restrict labour emigration or reliance on an overseas workforce? Here, it may be useful to distinguish between capacity and equity. Thus, although source countries may have the capacity to supply large numbers of English-speaking care workers, it does not follow that the double burden of training care workers for export as well as staffing local services should rest on lower-income countries (Hawkes et al. 2009). Such considerations are permeating global policy agendas. In the case of nurse migration, for example, approaches that emphasize planned self-sufficiency are challenging managed migration approaches that seek to reconcile the needs of all those involved in this industry. A growing number of countries (such as Norway, Iran, Australia, Oman and Malawi), regional formations (like CARICOM), international organizations (for example WHO and the World Health Assembly) and health professional organiz-

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ations (like ICN, WMA, BMA and HEAL) support this policy agenda. They see it as addressing the inequities arising from developed countries' growing dependence on foreign-trained nurses, the burden this places on developing countries and their populations' loss of access to care services (Little and Buchan 2007; Yeates 2010).

GCC research: what remains to be done?

Since the original formulation of the GCC construct, GCC research has highlighted how heterogeneous forms and contexts of care labour migration map onto the diverse care sector. This work has brought into view diverse structures of care labour production, coordination and governance. It elucidates network length and intensity of connectedness; directions and dynamics of care migration; the effects of care migration on individuals, families and household formation and on the wider social fabric, including health and welfare systems and social development; and the impacts of intersecting social divisions and inequalities in care migration on the production of and access to care. GCC research, however, is by no means complete. The discussion now proceeds to identify future directions and priorities for GCC research. I identify three main issues. First, GCC analysis may reinforce care work as women's work. Second, GCC research has tended to privilege certain aspects of transnational care mobility over others. Third, GCC analysis privileges particular scales of care provision and may inadvertently reinforce the analytical significance of the nation-state in the globalization of care mobilities. In what follows, I briefly outline and discuss each of these points and their implications for GCC research.

GCCs reinforce care work as women's work

Although the GCC concept was couched in gender-neutral terms ('personal links between people across the globe based on the paid or unpaid work of caring') the focus on transnational mothering defined GCCs as turning on female labour. This has channelled the focus of research into migrant women, feminized meanings and acts of (transnational) care-giving and essentialized forms of nuclear family. The development of GCC analysis in the ways described earlier in this article has contributed to decentring the focus on motherly care. It achieved this first, by including migrants other than those providing childcare and domestic care, second, by recognizing that not all female migrant care workers are mothers, and third, by attending to men participating in care labour migration streams.[6] This has facilitated a better understanding of the gendered transnational care economy, gender fluidity in care migration processes and multiple ways of caring.[7]

However, the decentring of female labour and alternative imaginaries of care practices is incomplete. The GCC literature remains overwhelmingly focused on female care workers, 'motherly' care and the ways in which this emigration adversely affects the quality of migrants' care-giving practices. While this focus retains the political attention on women, it arguably reinforces dominant sociocultural constructions of care work as women's work and feminized meanings and practices of care. This risks marginalizing feminist criticism of globalization (and the study of it)

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and the gendered ideologies, social morphologies, practices and effects of care transnationalization. It also serves to recreate particular imaginaries of care that essentialize particular forms of nuclear family. Hochschild presented the depleting effects of GCCs through the loss of physical contact time (which the carer spends elsewhere with someone else's child or children) and the transfer of love to the new children at the expense of the carer's own offspring. Yet care, particularly in the form of 'love' or caring about, is not a finite commodity. Emigration does not close down migrants' care identities and practices; it transforms them and diverse forms of care-giving practices continue on a daily basis from a distance, facilitated by communications and media technologies (Baldock 2000; Parreñas 2001, 2005). These multiple ways and forms of caring across distant and proximate geographies need to be placed centre stage.

At one level, correcting such biases and omissions involves attending to the sex arithmetic of care migration. Discerning the differential social positions of men and women in care labour migration streams involves more research on both male and female migrant workers in 'feminized' care occupations (like domestic work and nursing) and 'masculinized' ones (like psychiatry and surgery). However, gendering GCCs needs to go beyond the sex arithmetic of care migration streams to draw attention to the gendered properties, dynamics and effects of the care chain as a whole. At another level, then, GCC research needs to attend to constructions and representations of masculinity and femininity circulating and concretized in the globalizing care economy. These in turn need to be clearly related to wider social structures and processes operating in source and destination countries and transnationally. This work needs to extend beyond gendered identities, circumstances and motivations of care workers themselves to encompass the multiple actors participating in the care chain. These actors range from families, kinship and community networks through policy complexes bearing on care labour migration to employers to labour recruitment, brokerage, transportation, settlement, integration and advocacy industries. Ultimately, however, and in keeping with the tenets of network methodology, we need to retain the global network as the foundational unit of analysis.

Finally, GCC research necessarily needs to engage with complex intersections of gender with social divisions of 'race', ethnicity, religion, class, age, disability, sexuality and locality. A gender theory of GCCs needs to be able to ascertain, for example, how the labour that both male and female migrants provides generates surplus for consumption by those further up the care chain together with how multiple social divisions and relations of inequality inflect these processes of extraction and (re)distribution. The theoretical developmental work involved in this is outside the scope of this article, but suffice it to note here the potential benefits of such an encounter for both GCC analysis and intersectionality theory. In particular, the latter has developed within the confines of methodological nationalism. It therefore stands to gain much by engaging with the socio-spatial dynamics of multiple, interlocking social divisions and with methodological transnationalist analyses more generally.

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GCCs privilege certain groups, sectors and dynamics of care transnationalization

GCC research has broadened considerably over the decade. It now encompasses a wider range of occupations (domestic workers, nurses and religious workers), work settings (households, hospitals, nursing/care homes, convents/lay religious institutions), geographical areas (Europe, North America, Gulf States and South and Southeast Asia), types of care provision (mainly social, health, spiritual care), and types and dynamics of care migration (waged and unwaged care workers). Nevertheless, we need more research, encompassing additional occupations, contexts and dynamics of care labour migration, to address diverse global care formations, their dynamics, effects and impacts. For example, much has already been undertaken on global domestic care chains, but most of this has been about 'interior' domestic work (childcare, care of the elderly, cleaning) rather than 'exterior' housework (odd-jobbing, gardening), and remarkably little of this has looked at more institutionalized work contexts in which 'domestic' care takes place (for example for-profit and not-for-profit childcare centres). Similarly, the extensive work on global nursing care chains merits further texturing in relation to diverse geographical, historical and institutional contexts. In this context, it is also worth noting that, compared with nursing, next to no GCC research has been undertaken on other health workers or on other care occupations in which migrants are present – notably social work and teaching. Generating more case studies that are empirical in nature would benefit theory building, as well as the development of comparative GCC analysis. These efforts would help ascertain why, for example, certain GCCs are longer or shorter, better or worse connected than others; how different GCCs embody intersecting social divisions, and to what effect; and how confluences of various factors propel, and shape different GCCs at different points in time.

Territoriality and locality deserve special consideration in all this. Although GCC analysis fares well in disaggregating geographies/territorialities of care, the recruiting experiences of rich Anglophone countries (notably North America, Europe and Australia, and to a lesser extent the Gulf region) as destination countries are privileged. At the same time, 'developing' countries tend to be constructed as sources of migrant care labour. This focus emphasizes particular dynamics of care migration, overlooking the considerable extent of care migration that is occurring on a 'South–South' basis (Bakewell 2009; Piper and Roces 2003; Yamanaka and Piper 2005), on a North–South basis (Yeates 2009a) and on a North–North basis (Yeates 2010), especially among non-Anglophone countries. Incorporating the recruiting and sending experiences of a wider range of countries worldwide would generate a better understanding of GCCs starting and ending in different parts of the world and elucidate a range of tangible manifestations of and responses to the care 'crisis'. We need to link these manifestations and responses to wider social structures and processes of socioeconomic change. Just as the transnational domestic care service economy historically contributed to industrialization processes in Western care labour exporting and importing countries alike (Katzman 1978), so contemporarily the care crisis that has beset the West/'advanced' economies is also now impacting on

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'developing' Asian countries, with the later onset of this crisis reflecting the later stage of industrialization.

Finally, the risks of fetishizing migrant care workers as the prototypical embodiment of care transnationalization merit emphasis. The care labour migration with which GCC analysis has been concerned is just one form of care transnationalization, namely that involving the movement of service providers to users. But, there are other forms of care-related migration that could be usefully addressed. These include migration to consume care services abroad, as in medical travel (for consultations, tests, operations, transplants, post-operative and rehabilitative care), retirement migration (facilitated by portable rights to health and social care overseas, and return migration prompted by quality of health and social care abroad), sex tourism and marriage. Developing and applying network methodology to these other forms of care migration would shed light on different socio-spatial dynamics of care transnationalization to those that GCC analysis has thus far revealed. Regretfully this work lies outside the scope of this article.

GCCs privilege particular scales of analysis

Decentring the nation-state as the foundational unit of analysis has opened up the field of care studies to different scales of care organization and provision than previously considered. This has generated major conceptual, theoretical and methodological innovations in the ways that the field of study is constructed. However, GCC analysis and research may inadvertently reify the nation-state. Thus, attending only to care formations, relations and practices transcending international state borders reinforces the importance of those very borders in the definition of what is a 'global' care chain and what is not. As Wimmer and Glick Schiller (2002) argue in relation to migration studies more generally, focusing only on border-crossing migrant care workers reinforces the social categorization of people based on their nationality or national origin. It places undue emphasis on nationality in explaining (for example) social mobility and integration, and (re-)naturalizes the global system of nation-states and 'container' notions of state-society.

To help resolve this tension, I suggest returning to first principles. The value of network methodology is precisely its identification of (care) networks that are 'by nature neither local nor global but are more or less long and more or less connected' (Dicken et al. 2001 citing Latour 1993). If the usefulness of the GCC construct is its ability to illuminate the *multiplicity* of scales across which the social organization and relations of care operate, we also need to be sensitive to networks that do not necessarily transcend international state borders as well as to the ways in which global economic restructuring impacts on care migration. This opens up new avenues for GCC analysis that are cognizant of intra-national as well as international care migration. It opens up the field to care migration dynamics in intensely populous countries like China, India and Indonesia where there are hundreds of millions of internal migrants (Hua Wan 1995; ODI 2006). With internal migration expected to rise at a faster rate than international migration (ODI 2006), questions about how

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economic globalization conditions internal care migrations (most of which are rural–urban) and what are the disjunctures and continuities between internal and international care migration become pressing. Here, it is worth noting that internal migration often precedes international migration and that both are a response to the (global) economic restructuring that necessitates supplementary labour reproduction strategies, including the geographical dispersal of family members. With the globalization of agriculture displacing people from the countryside, global depeasantization (Araghi 1995) feeds urbanization and the growth of world cities. Meanwhile, the prospect of work in world factories or in the formal care services sector, which is expanding in the face of ruptured systems of familial care and the identification of new sources of profit, draws rural dwellers to cities at home and abroad (Yeates 2001, 2009a).

I therefore suggest that an enhanced emphasis on multiple scales of care, and attention to how these relate to processes of global economic restructuring, could help overcome the problem of international political borders in GCC scholarship. This is no retreat from GCC analysis. Rather, it adds additional scales of analysis and re-emphasizes the links between internal and international migration. It would shift attention from a sole focus on global (care) networks to (care) networks of varying length and connectedness and raise the question of why certain networks are longer and more intensely connected than others are (cf. Dicken et al. 2001 citing Latour 1993). This would additionally reflect an embedded understanding of transnationalization as the playing out of transnational processes within as well as across national territories, whether through cultural identities, social institutions, economic interactions or political processes, and the enmeshment and co-construction of multiple scales of social life.

An elaborated sense of the 'global' in GCC analysis needs to retain a clear focus on relations and expressions of power that are rooted in care formations – be it 'power to control resources, influence events, participate in the economy and to exclude or marginalize' (Dicken et al. 2001: 94). GCCs need to reveal the dynamics and contradictions of economic globalization on whatever scale it operates or in whatever mediated forms and expressions it takes. Thus, we already have a good understanding of how care transnationalization relates to geographies of development and restructuring, how it exports 'domestic' crises overseas and enhances the lives of some at the expense of others. However, GCC research tends to focus on a critique of neo-liberal welfare capitalism at the expense of the varieties of welfare capitalism worldwide. Far from retreating from grounded, embodied analysis of power that has already developed in GCC research, this simply emphasizes the necessity of attending to the multiple sites and scales across which the global (care) economy operates and through which power is circulated, concretized and expressed.

Conclusions

Over the last decade, GCC analysis and research have been at the forefront of a vibrant feminist research agenda focused on the transnational characteristics, dynamics and impacts of care work and the care services sector. This body of work

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has been generative of innovations in understandings of the relationship between the social relations of care (and welfare) and globalization processes. Grounded in network methodology and with a clear focus on *global* networks, this research agenda combines a focus on transactions between identifiable agents dispersed over vast distances, and on social structures characterized by social relations of inequality and inequitable access to resources and power.

The scope of GCC research has developed considerably over the last decade. From an initial concern with the Filipino–USA nanny trade in the contemporary era, and with international networks of families linked through market and non-market relations, GCC research now also focuses on a range of care labour migrations in different occupational, organizational, regulatory, historical and locational settings. It also looks at the ways in which these forge relations of interdependence between health and welfare institutions and systems (as well as between individuals and families) across distant and proximate geographies. The various theoretical and empirical insights resulting from this expansion have brought far greater emphasis on complex networks and complicate the image of linearity that the chain metaphor invokes. They have stretched the notion of care work to recognize the wide range of activities and occupations beyond childcare and domestic work it involves while maintaining a clear forms of care that identifiably involve promoting the personal health and welfare of those who cannot, or are disinclined to, do so themselves. With these developments, sophisticated understandings of care transnationalization processes as grounded, embodied and textured have also emerged. GCCs' focus on the relations between geographically dispersed but coordinated actors in the provision of a major social good and the structural outcomes of these interactions – what Yeates (2009a) calls 'distributive spatialities' – have highlighted the material linkages between people, social systems, welfare formations and places ostensibly separated by vast distances and political borders. They have also placed in the foreground specific mechanisms by which 'local' social divisions (of ethnicity, 'race', religion, sexuality, gender, class and locality) translate into new – and not so new – forms.

GCC analysis has injected methodologically transnationalist and geographical analyses into theoretical, ethical and policy-oriented analyses of care, and has tangibly contributed to wider efforts across the social sciences aiming to reconstruct a body of knowledge around care that is cognizant of the multiple socio-spatial scales involved in care provision. In this, it has fundamentally challenged orthodox constructs of 'national' care and welfare regimes, while also adding a substantial new arena in which the materialization of transnational processes is studied. By identifying multiple scales at which care relations and provision are concretized, GCC analysis contributes to decentring the 'container state' notion of society that creates artificial distinctions between 'domestic' and 'foreign' (societies, polities, labour and policies) shaping fields of enquiry and action. The development of knowledge about the extent and nature of care transnationalization has in turn enabled the identification of transnational policy and political responses. Issues of how to distribute welfare gains from care migration more justly have been at the foreground of the debate. These concern what kinds of regulatory and other measures need to be put in place to

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address the burden of the risks, costs and exploitation currently falling on migrants and developing countries, and how to shape the international trade in care migration in the interests of public health and welfare.

More work is required to fulfil the promise of network methodology and global social network analysis. This involves generating further case study material to capture the multiplicities of care transnationalization revolving around different migration dynamics. But GCC research also needs to be better anchored in gender and intersectionality theory. It needs to develop an embedded notion of transnationalization and to detail further an elaborated sense of the 'global'. The substantive work required to resolve these issues lies outside the scope of this current article, but tangible ways forward for GCC research have been suggested. These include enhanced attention to the sex (and more widely social) arithmetic of care migration; the inclusion of a wider range of care occupations in different organizational, regulatory, geographical and historical contexts; a focus on intra-national as well as international migration (and the relationship between them); and the development of comparative GCC studies.

Notes

1. Reproductive labour is essentially what creates labour power as opposed to commodities or products. We can distinguish between what is necessary for the biological reproduction of human beings (sexual labour), the maintenance of individuals through their life cycle (physical and emotional care labour involved in looking out for and looking after others) and systemic reproduction (education, social bonds and ties) to enable the social system to be sustained. Reproductive labour can accommodate an incredibly wide range of activities ranging from highly intimate social, health and sexual care services to less intimate ones such as educational, cooking, cleaning, ironing and general maintenance work offered on a waged and/or non-waged basis in domestic (household) and/or institutional settings.
2. For instance, the presentation of the production process by GCommC analysis differs markedly from that involved in the production of care. The former entails acquiring raw materials, processing raw materials, as well as distributing, marketing, consuming and recycling the finished commodity. The latter involves educating and training care workers, recruiting care labour, organizing the care service system, labour travelling to the site of service delivery, and service provision (Yeates 2004a, 2009a).
3. 'Caring for' someone refers to the performance or supervision of tasks involved in 'catering for the material and other general well-being of the one receiving care'; such tasks include cooking, cleaning, washing, listening and healing. 'Caring about' someone is 'having affection and concern for the other and working on the relationship between the self and the other to ensure the development of the bond' (Lynch and McLaughlin 1995: 256–7). It entails a set of perspectives and orientations, often integrated with tasks such as looking out for, and looking after, the other (Lynch and McLaughlin 1995: 258–9; Yeates 2004a). The conception of care includes a wide range of tasks and activities to promote the personal health and welfare of people who cannot, or who are disinclined to, perform those activities themselves. Because of this diversity, care studies – especially the policy-oriented end of it – tends to operate a more restricted usage, referring to 'custodial or maintenance help or services, rendered for the well-being of individuals who *cannot* perform such activities themselves' (Hooyman and Gonyea 1995: 3 citing Waerness 1985, emphasis added),

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typically ill, disabled, elderly and young people. However, this usage in turn raises a number of difficulties (see Folbre 2002).

4. Neither the New International Division of Reproductive Labour, Sassen's (2000) 'counter-geographies' of globalization nor Lopez's (this issue) concept of 'curoscapes' identify the specific mechanisms by which such international relationships are created and reproduced.
5. Thus, GCCs involving nurses working in large institutional settings employed by public authorities differ compared with GCCs involving nannies working in domestic settings and employed by individual households. These in turn differ from GCCs involving cleaners working for commercial domestic care corporations, from GCCs involving sex workers in a criminalized industry reliant on trafficked labour and from GCCs involving nuns working in care institutions managed and controlled by religious organizations where the profit motive is absent (Yeates 2004a, 2009b).
6. For example, Kilkey and Perrons's (2010) study of eastern European migrants working as handymen in England, Yeates's (2004a, 2004b) work on the clergy and priests in religious care chains in the Irish–US context, Manalansan (2004) on male careworker migration from the Philippines, and van Walsum (2009) on migrant men in domestic work in the Netherlands. Sarti (2008: 90–1), in her overview of domestic work from an historical perspective, touches briefly on male servants.
7. With this has come recognition that 'feminine' traits are reinforced through 'intensive mothering' (or 'daughtering' – cf. Baldock 2000) and modified to incorporate 'masculinist' conceptions of breadwinning as caring (Parreñas 2001; Schmalzbauer 2004).

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