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Going Global: The Transnationalization of Care

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ABSTRACT

This article critically examines the contours of 'care transnationalization' as an ongoing social process and a field of enquiry. Care transnationalization scholarship combines structural understandings of global power relations with an emphasis on social interactions between defined actors in ways that keep sight of human agency, material welfare and wider social development. It has, however, tended to privilege particular forms, dynamics and sites of care transnationalization over others. The body of research on care labour migration, which is otherwise the most developed literature on care transnationalization to date, contains a number of biases and omissions in its coverage of border-spanning relations and their mediation across country contexts. At the same time, other significant forms of care transnationalization, such as those involving consumer-based care migration, corporate restructuring and the formation of care policy, have suffered from comparative neglect. Working towards an integrated agenda that addresses these diverse expressions of care transnationalization and how they 'touch down' in a range of sectoral, social and country contexts is of prime importance to policy research agendas directed at understanding the wider development impacts of processes of social and economic restructuring.

INTRODUCTION

Ongoing processes of global restructuring have inspired the development of research agendas attentive to the diverse and complex ways in which socio-institutional formations and practices across distant and proximate territories are materially connected. These agendas are generating new theoretical understandings of social structures, relations, identities and practices as stretching across national terrains (rather than confined within them) and of a world made up of dense networks of border-spanning connections, interactions and effects.

Care occupies a key place in this research agenda because of what it reveals about the nature of these border-crossing webs of socio-economic relationships. At one level, it illuminates a facet of economic restructuring that tends to be neglected by orthodox literatures on the subject

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(e.g. OECD, 2006). Care services are essentially oriented to the (re)production of beings and do not necessarily 'add value', at least in the market exchange sense of the term. They are provided on an unwaged/unpaid as well as on a waged/paid basis and the majority of such services are not produced by for-profit firms, but by governments, non-profit organizations and households operating outside of the commercial sphere. They are guided as much by relations of social solidarity, obligation, altruism and reciprocity as by market exchange, preference, choice and economic gain. They constitute a major component of public and private economic activity and expenditure, make significant contributions to GDP and national wealth and are essential to social reproduction without which production systems could not operate. As such, a focus on care captures forms and dynamics of services restructuring obscured by a focus on commercialized operations and transactions revolving around the production of commodities ('things'). And it brings into view wider sets of considerations and calculations behind the provision and reform of services that a focus on marketized transactions and for-profit logics alone is not fully equipped to address.

At another level, a focus on care brings to light the ways in which the social organization, relations and practices of welfare are being 'stretched' over long distances and structured across national borders. Care provides a productive lens through which to examine how societies are structured, how different social groups are positioned within them (including how these positions are mediated by economic and welfare institutions), and the consequences of these structures and modes of social organization for access to major resources (Pascall, 1997). Such questions have traditionally been addressed through the lens of methodological nationalism which privileges a single socio-spatial scale (the nation state) and attends only to domestic sources of power, political actors and modes of service provision (e.g. Daly, 2002a, 2002b; Williams, 2010). But as evidence of the significance of care to the formation of 'multi-stranded' social relations routinely linking societies of origin and settlement (Basch et al., 1994) mounts, so recognition of the implications of these relations for understanding the transnationalized nature of care formations is also growing.

This article critically examines the contours of 'care transnationalization' as an ongoing social process and as a field of enquiry. I argue that this body of scholarship usefully combines structural understandings of global power relations with an emphasis on social interactions between defined actors in ways that keep sight of human agency, impacts upon material welfare and wider social development. However, this scholarship has privileged particular forms, dynamics and sites of care transnationalization over others. In particular, the literature on migrant care workers, which is otherwise the most developed to date, contains a number of important biases and omissions regarding different kinds of border-spanning care relations. Other modes and expressions of care transnationalization — such as those involving consumer-based care migration, corporate restructuring and

policy formation — have not yet enjoyed similar levels of scholarly attention with that literature or have been developed outside a care transnationalization theoretical framework. I argue that addressing these biases and deficits is central to the future development of a transnational analysis of care. This involves deepening analyses of how different forms of care transnationalization are expressed across different country, social and policy contexts, as well as furthering understandings of the connections between seemingly disparate modes of care transnationalization. It will need to intensify the dialogue between methodological nationalists and transnationalists and deploy the methods of comparative policy analysis.

The discussion is organized around four main sections. The first section provides preliminary clarification of the concepts of 'care' and 'transnationalization', while the second section reviews varieties of care transnationalization and different kinds of transnational entity involved. Here, I argue that a transnationalization framework has the potential to reveal multiple forms and dynamics of care restructuring and the existence of diverse care structures linking populations and places around the world. The discussion in the third section critically reviews research literatures focused on producer-based care migration to elucidate the ways in which they reveal the transnationalization of economic flows, social formations, political action and ideational consciousness. The final section then takes overall stock of care transnationalization research as it has developed to date and considers the implications of this discussion for future research attentive to diverse expressions, sites, scales and dynamics of care transnationalization.

CARE TRANSNATIONALIZATION: DEFINITIONS AND APPROACHES

The concept of care refers to activities and orientations to promote the physical and social (re)production of 'beings' and the solidary-affective bonds between them. Care activities refer to the performance of tasks (and the supervision thereof) involved in 'catering for the material and other general well-being of the one receiving care'. These tasks range from the highly intimate (personal, social, health and sexual care) to the less intimate (cooking, cleaning, ironing and general maintenance work), and take place in diverse settings (household, community, institutional contexts) (Yeates, 2004, 2009a). The orientational aspects of care involve emotional labour, expressed variously as 'looking out for' the other, '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, cited in Yeates, 2004). In some formulations, these orientational aspects include those which are directed at oneself rather than only at others. It is also important to distinguish emotional care labour from spiritual (or religious) care labour. Spiritual care addresses the meta-physical dimensions of existence of the self and the well-being of the other; it is distinct from the

emotional bonds developed from a personal, affective relationship between the self and the other. Like affective care, though, religious care entails a set of perspectives, which are often integrated and provided in conjunction with tasks, such as looking after the other. Thus, social, educational and healthcare services may involve one or all of emotional care, spiritual care and physical care (Yeates, 2009a).

This definition of care and of care services is able to accommodate incredibly diverse phenomena. By some accounts, it becomes operationally meaningless as most work contains elements of 'looking out for' the other. Because of this, often a more restricted interpretation of care is employed, referring to 'custodial or maintenance help or services, rendered for the well-being of individuals who *cannot* perform such activities themselves' (Waerness, 1985, in Hooyman and Gonyea, 1995: 3, emphasis added) — typically ill, disabled, elderly and children and young people (Daly, 2002a). However, this may miss important elements of care work, such as that provided for people who are able to perform such activities for themselves but are not inclined to do so (as in domestic work and 'breadwinning') (Folbre, 2002). These definitional problems of what care work is and what it is not alert us to the complexities of the subject. Such complexities have been the subject of extended (and inconclusive) debate across the social sciences for much of recent history. But, ultimately, what is important is to understand that care as an orientation and a practice is routinely 'stretched' over vast distances in ways that have material importance for questions of who provides and consumes care, under what conditions, and with what effects for access to services, the quality of rights and the distribution of resources within and between countries.

A second axis of debate concerns the relative merits of psychological, labourist and philosophical approaches to care. Psychological approaches to care giving emphasize individual motivations, emotional attachments and identities of care givers; labourist approaches conceptualize care giving as labour, be this physical, emotional or spiritual labour (as above); philosophical approaches emphasize the moral and ethical dimensions of care giving. Of the three, labourist approaches have been most developed in contemporary care transnationalization literatures and have most affinity with contemporary policy reform agendas. But each perspective has the potential to bring useful and complementary insights to the question of how transnationalizing forces mediate care as an orientation and as practice, how these forces are restructuring modes of social organization and social relations, and how these are giving rise to 'new' forms of consciousness and awareness that are finding their ways into political discourses, collective action and policy initiatives.

Finally, we need to recognize the distinctiveness of a transnationalization perspective and how it differs from internationalization and globalization perspectives. Internationalization refers simply to the geographical dispersion of ideas, activities and practices across political borders, from one

country to the next; it implies no simultaneous 'backward' or 'forward' linkages, whereas transnationalization does. Indeed these multiple linkages are an essential definitional element of transnationalization. The distinction between the two is illustrated in relation to migration processes. An international perspective sees directed movement from one point of departure (country A) to a point of arrival (country B) and focuses on settlement and integration of migrants into country B. A transnational perspective emphasizes the blurring of social space and geographic space, as migration implies less a rupture of relations with country A after having arrived in country B than ongoing and simultaneous relations with countries A and B. The distinction is captured in the term trans-migrants in opposition to international migrants, echoing similar terminological distinctions in the characterization of corporations — transnational corporations (TNCs) vs multinational corporations (MNCs).

While transnationalists and globalists share a common interest in actors, entities and processes that transcend nation states, transnationalists are sceptical of 'meta-individual imaginations of "deep structures"' (Dicken et al., 2001) that read care migrations off macro-structuralist 'logics of capitalism' scripts of the global system. Instead, they place greater emphasis on the actual interactions and transactions involved and assign a greater role to agency power in shaping outcomes (Khagram and Levitt, 2004). This does not negate structural forces or lapse into banal methodological individualism: the relational approach emphasizes the (re)production of a border-spanning web of relationships while avoiding '"atomistic description(s)" of activities of individual actors' (Dicken et al., 2001: 91). The focus on social interactions between defined actors and their empirical outcomes enables structural understandings of global power relations and social structures propelling and sustaining trans-bordering processes (of people, ideas, capital) together with an emphasis on human agency to be kept in view (cf. Dicken et al., 2001; Holton, 2008; Yeates, forthcoming 2012).

VARIETIES AND EXPRESSIONS OF CARE TRANSNATIONALIZATION

Care transnationalization refers to the processes of heightened connectivity revolving around consciousness, identities, ideas, relations and practices of care which link people, institutions and places across state borders. Following Vertovec (1999), we may distinguish between the different *conceptual premises* underpinning articulations of care transnationalization. These include border-spanning social morphologies (e.g. migrant networks, ethnic diasporas, transnational families); a type of consciousness (e.g. awareness and concern for the well-being of one or more 'distant' others; dual/multiple identities of belonging); a conduit for capital flows (e.g. remittances of goods and money, transnational care corporations); a site of political engagement (e.g. global public fora and cross-border spheres of governance through

Table 1. Transnational Entities and Examples of Care Ideas and Practices Promulgated

Type	**Definition**	**Ideas and practices**
Epistemic communities	Experts linked around the production and dissemination of scientific ideas, knowledge and policy advice	Research institutes, think tanks, consultants undertaking research and providing advice on policy relating to care migration, service provision and regulation
Transnational advocacy networks Transnational social movements	Individuals linked around common moral and political concerns and discourses	Articulation of ethical and moral concerns about care migration; defence of migrants' rights; claims making to enhance the quality of social protection
Transnational migrant networks; ethnic diasporas and networks Transnational family networks	Individuals linked around a common experience; exchanges of information, goods and services; shared values or aspirations; familial and/or ethnic ties and bonds	Exchanges of care employment, recruitment and employer information Provision of emotional and practical support from a distance e.g. listening, homework tuition, financial support through remittances
Transnational consumer networks		Exchange of information about health and social care providers, products and services
Transnational corporations	Corporate and other economic entities in pursuit of economic gain and profit	Staffing/care labour recruitment Health and social care service provision (hospitals, nursing homes, home healthcare, childcare, nurseries).
Transnational criminal networks		Trafficking and smuggling of humans e.g. for sex and domestic work
Transnational professions	Care professionals linked around knowledge and technical expertise	International Guild of Catholic Nurses; International Council of Nurses
Transnational governmental networks Cross-border spheres of governance	Governmental actors linked around a common issue or concern	IGOs (e.g. World Bank, OECD, European Union, ILO) promulgating care discourses and policies on health migration, medical travel, health and social care provision, work–family reconciliation

Source: adapted from Khagram and Levitt (2004).

which claims making is directed and care policies are constructed), and the reconstruction of place or locality (e.g. care identities, orientations and practices that connect and position actors in more than one country). Care transnationalization is an ongoing process involving diverse phenomena, but it is not an amorphous or 'disembodied' one. We may identify a range of expressions of care transnationalization and actors involved. Table 1 accordingly

identifies a range of *transnational entities* and provides examples to illustrate their involvement in the promulgation of ideas and practices around care.

Table 1 reveals the diverse range of transnational entities (epistemic communities, governmental networks, professions and social movement organizations), the motivating forces (contrast, for example, the logics of for-profit entities with the moral logics of advocacy coalitions and social movement entities) and the varied nature of transnational care networks (from transnational families to consumer organizations to labour recruitment networks to advocacy coalitions). These networks act as conduits through which economic, ideational and informational resources circulate and position dispersed people, places and institutions in relation to one another. Ideational circuits, for example, may involve, be directed at, or expressed through, border-spanning public fora and spheres of cross-border governance; but they also circulate through 'national' spheres of governance. Much of the focus on ideational modes of care transnationalization has been on highly visible sites of global governance (IGOs), but the circulation of ideas within and across countries (some of which emanate from global fora) is also of importance to understanding how 'national' formations, the definition of policy problems and the formulation of domestic responses to them are co-constructed by processes of transnationalization.

Conceptually, ideational networks are often distinguished from networks of care labour and economic resources. The latter networks are the subject of a more detailed review in the following section, so suffice it for now to simply note that examples include labour networks of migrant domestic workers or other kinds of care labour (e.g. health workers), and that they are at once constituted by, and formative of, personal, familial and institutional relations over long distances. We may also distinguish between different kinds of producer-based care networks: those based on the migration of care labour and those revolving around corporate entities. Transnational care corporations include recruitment agencies mobilizing and supplying care labour as well as entities directly providing care services. These may operate on a 'for-profit' basis (as in corporations providing medical care, childcare and long-term care) or on a not-for-profit basis (as in international voluntary sector organizations providing diverse kinds of care services within emergency and development aid contexts).

Producer-based care networks differ in nature from consumption-based networks based on movements of people to the point of care service provision. Examples of the latter include medical travel and retirement migration. Space constraints only permit the briefest of commentary, but both medical travel and retirement migration are motivated by the search for more affordable, accessible, timely and/or specialized medical and social care anticipated to deliver a better quality of life than is possible in the home country. These migratory dynamics reflect uneven development, emanating from wealthier groups (i.e. those with greater consumer power) in developing and industrialized countries. Whereas producer-based care migration

tends to involve movements from poorer to richer countries, medical travel and retirement migration tend to involve movement from richer to poorer countries. (One exception to this is medical travel in contexts where access to certain kinds of healthcare services of member state citizens is facilitated by multilateral agreements on portability of entitlements, such as in the EU.)

In the expansion of medical migration we see the development of transnational corporate care markets. Such markets are sponsored by developing country governments seeking foreign revenue and the socio-economic development they believe it will deliver. These markets are also sponsored by governments in neighbouring countries in the region as well as by those further afield seeking to move particular forms of healthcare provision offshore at lower cost. As Whittaker makes clear in the Indian context, where private healthcare has significantly expanded over the last two decades:

> The Indian Apollo Hospital Enterprises, the largest medical corporation providing services to foreigners and which treated an estimated 60,000 patients between 2001–2004, exemplifies global corporatised health with either ownership or partnerships with hospitals in Sri Lanka, Muscat, Dubai, India, Nepal, Tanzania, and Bangladesh. It also provides 'outsourced' medical services to treat patients from Tanzania and Mauritius sponsored by their governments and has negotiated to provide tests and do operations for the British National Health Service (CBC news online 2004). (Whittaker, 2009: 4)

Medical markets tend to be dominated by hospitals owned or managed by large multinational medi-corporations providing advanced facilities oriented towards more profitable procedures and catering for wealthy patient-customers drawn from local elites and from abroad (often including from ethnic diasporas). They form a key part of wider healthcare complexes involving transnational circuits of medical technologies and techniques circulating between hospitals. These circuits are flanked by parallel circuits of health professionals drawn from skilled medical staff in the domestic public health system as well as those practising overseas (Leng and Whittaker, 2010; UNESCAP, 2008; Wibulpolprasert et al., 2004).

In retirement migration, too, we see poorer countries competing for a larger share of expanding international markets for rich retirees. Like medical migration, retirement migration also involves the relatively wealthy and well educated moving from richer to poorer countries to capitalize on their superior purchasing power whilst maintaining ongoing ties with the home nation. Often these markets develop on a regional basis. In Europe, retirees from the Nordic countries move to the Mediterranean region countries such as Portugal, Italy, Greece, Turkey, Hungary and Spain (King et al., 1998). In Oceania, Australia and New Zealand are popular among retirees from northern Europe and East Asia (Shinozaky, 2006, cited in Morales, 2010). In the Americas, Costa Rica, Guatemala, Colombia, Brazil, Argentina and Mexico attract retirees from the United States and Canada (MPI, 2006; Morales, 2010). South-East Asian countries, such as Malaysia, Thailand and the Philippines are popular destinations for Japanese, Chinese, Taiwanese

and Korean retirees (Shimizu, 2009). With the development of these markets comes the redirection of purchasing power and other forms of economic activity, as well as substantial relocations of social and healthcare costs to the destination country (Gustafsen, 2001; Williams et al., 1997).

Of note is that retirement migration may involve a sexual element, in that access to sexual care is often closely bound up with access to social and health care. As Shimuzu (2009) notes, for many of the Japanese men moving to the Philippines starting a new life with a new young (Filipina) partner, sexual care is integral to the care package they anticipated they would be able to access. Morales' (2010) study of US retirement migration to Mexico similarly draws attention to the significance of marriage in noting the preponderance of retired citizens (mostly US men) marrying local people (Mexican women). Here, the strategic economic calculation behind such marriages is evident in that 'it allows [US men] to buy property without the expense of the trust that must be paid by foreigners to own property in Mexico' (Morales, 2010: 80).

The distinction between ideational and service-based care transnationalization is useful conceptually but such distinctions are not necessarily evident in practice. For example, migrant networks based on care work have evolved in conjunction with advocacy-based and professional networks. Commercial care corporations' networks have developed alongside transnational political coalitions representing their economic interests in spheres of policy formation. And the rise of consumer-based care migration has been accompanied by transnational consumer networks cohering around information exchange and advocacy campaigns.

CARE TRANSNATIONALIZATION: THE EXAMPLE OF PRODUCER-BASED CARE MIGRATION

The most studied forms of care transnationalization to date concern those involving cross-border migration processes. This emphasis on migration is unsurprising given the importance transnational studies attaches to the movement of people as a pre-eminent mode/expression of transnational activity and consciousness and as a conduit for further transnationalisms, be they economic (e.g. remittances), social (ethnic diasporas, migrant networks), or political (e.g. migrant advocacy and coalition campaigns) in nature. Of all the forms of care migration as a mode of transnationalism and as a conduit for transnationalization, most attention has been paid to the migration of care workers. Essentially concerned with movements of 'natural persons' (i.e. as opposed to corporate or governmental entities) involved in the production of diverse care services from one country to another (or others), this migration is seen as formative of sustained social relations between disparately-located individuals, families, welfare institutions and economic systems.

This section examines the main contours of such care migration in some detail, to illustrate some of the key ways in which it can be said to be

transnationalized (or transnationalizing). This discussion emphasizes the following aspects of care labour networks: as conduits for transnational economic flows (remittances of goods and capital) and transnational ideational flows (ideas and ideologies of care); as constituted by and formative of border-spanning social formations (global care networks, transnational families); and as an object of transnational collective action (e.g. advocacy and coalition campaigns, policy formation/responses in and through domestic and/or global fora).

Over the last two decades feminist care research has emphasized the extent to which women from 'peripheral' countries migrate to 'core' countries to undertake care labour. Much of this work has focused on transfers of 'motherly' care (particularly domestic work and childcare) in individualized household contexts, and the forging of a web of personal relations spanning the globe based on the provision of paid and/or unpaid care work. Hochschild (2000) and Parreñas (2001, 2005) portrayed a world criss-crossed by 'chains' of migration and love where mothers in mainly peripheral countries leave their children to the care of others while travelling to mainly metropolitan areas in core countries to care for the children of other women, either to release these women to undertake paid work in the formal economy or for status reasons. Migrants are a crucial source of labour easing the care burden of a growing number of households (read: women) in richer countries as they struggle to balance the demands of paid employment with their continuing responsibility for domestic work and other (unpaid) forms of care (Yeates, 2009a).

These flows need to be placed in the context of greater population movements generally and the feminized nature of contemporary international migration in particular, both of which are a response to the problem of uneven development. State policy, including social policy, shapes the scale and directions of these flows. Recruiting households are embedded in socio-institutional formations that foster — to varying degrees — reliance upon forms of work characterized by socio-economic insecurity. The development of tax and welfare benefits and labour regulations in rich countries construct care work as poor work and facilitate migrants' entry into it, where they compensate for the inflexibility and inadequacy of public social and healthcare services (Bettio et al., 2006; Escrivá, 2004; Piper, 2007a; Ungerson, 2002; Williams, 2010). Bretton Woods policies require governments to spend more on debt repayments than on social and healthcare services provision and are supportive of pro-'free' market policy reforms in developing countries that erode livelihoods, suppress wages, devalue currencies and promote export-oriented economic development. This, together with the fact that those countries may have little else to sell on the world market but labour power, renders the export of female labour central to the international politics of debt. Indeed, migration to richer countries represents a major means by which individual families generate income necessary for economic survival and welfare provisioning, while remittances are one of the few means by which some poorer countries can generate foreign currency

and securitize loans (World Bank, 2011). Not surprisingly, then, international export of female labour is explicitly sponsored or tacitly condoned by governments, with care labour export an increasingly significant element of industrialization and economic development strategies (Yeates, 2009a). With these export-led strategies also come attempts to foster migrants' continuing relations with their 'home' country, including the development of taxation policy to foster favourable returns on inward investment (cf. 'Non-Resident Indian' in Indian tax codes) and/or to harvest a share of migrant remittances for general purposes (e.g. Philippines, Ghana).

Care worker migration is formative of border-spanning family care networks. Through migration, transnational networks of families are established, comprised of links amongst the same families (through the formation of transnational families) as well as links between different families (through the employment nexus). The literature on this subject clearly demonstrates the extent to which the provision of care labour is integral to the active, regular connections between and among transnational families. Whether the subjects of care are young (e.g. Parreñas, 2005) or elderly (e.g. Baldock, 2000), emigration transforms rather than closes down migrants' roles and identities as carers. Migrants themselves conceptualize their labour overseas and their sending of remittances as an act of care itself and, as 'distant carers', they also continue to provide tangible amounts of emotional and practical care work — often on a daily basis — from afar. This care work ranges from emotional support around issues of health, education and personal relationships, to practical support in the form of homework tuition, organization of family finances and the sending of remittances. Migrants remain involved in key forms of daily care activities and major decisions about educational, health and social care of their child(ren) and/or parents, and they are incorporated into networks of care provision involving family, neighbours, friends living in the vicinity of the elderly parent or child (Baldock, 2000). Even if caring from a distance amounts, by some accounts, to no more than semblant intimacy (Parreñas, 2001), migration reconfigures rather than closes down care roles, identities, power and status hierarchies within families and social networks (Asis et al., 2004).

These analyses have been crucially important for revealing 'new' global dynamics of care provision and restructuring, including the formation of global relations of social inequality between geographically dispersed men, women and children. But migration is formative of global care networks beyond 'private' familial networks, as captured by the 'care migration-industrial complex'. This concept conveys the degree of coordinated action among public and private actors to produce, recruit, relocate and settle care labour abroad, and to facilitate them in actively maintaining their ties 'back home' (Yeates, 2009a). Networks are based on (but not limited to) economic exchange; they link health and social care institutions (including those involved in the formation of 'human care capital' such as education and training organizations), and generate significant (often negative) externalities for public health and welfare institutions and populations in poorest

countries. As the concept of 'global nursing care chains' reveals, the characteristics of these global care networks are an expression of the global status of countries:

> Countries at the top of the chain are 'fed' by those lower down the ranks: for example, the United States draws nurses from Canada; Canada draws nurses from England to make up for its losses to United States; England draws from South Africa to fill its vacancies; South Africa draws on Swaziland. Countries at the bottom end of the nursing chain may supply international markets but not replenish their stocks by importing health workers from other countries: the Philippines is a major example of this. The problem for such countries is that they have no further countries from which they may recruit to make up for the losses of their own nurses. . . and consequently experience nursing shortages. (Yeates, 2009a: 80)

Broadening the scope of attention from 'unskilled' care workers in individualized household contexts to also include more skilled migrant carers working in highly institutionalized, professionalized and regulated contexts draws attention to the 'public' face of transnationalizing care including the existence of looped circuits (rather than one-way chains) of connection from richer countries to poorer ones. It highlights how those countries which have no other (i.e. poorer) countries from which to recruit may become reliant on charity. This is evidenced in the case of health worker migration, where nursing (and medical) labour is often provided by the very same countries that have recruited nurses from poorer ones. This is illustrated in the case of Malawi, whose long history of nurse emigration (mostly to the UK) is paralleled by a more recent history of importing nurses from overseas under the auspices of donor aid programmes. Nurses comprised a sizeable proportion (about one in five) of volunteers mobilized by UN Volunteers and the UK's Voluntary Services International as part of the Emergency Human Resource Programme, a donor aid package to Malawi operational since 2005 (MSH, 2010; Muula, 2006). This 'counter-migratory' dynamic is an integral part of the same global political economy of care propelling and sustaining migration from middle- and low-income countries to high-income countries (Yeates, 2009a, 2011a).

The complexities of global care networks are further elaborated in a markedly different form of care transmigration — that involving the religious. My research into the organized production and export of care labour by Ireland throughout the nineteenth and twentieth centuries testifies to the pivotal importance of the Catholic religious to the formation of sustained social relations linking Ireland to the many countries worldwide to which the Irish migrated (Yeates, 2009b). The female religious were central to the establishment of various care (and more general welfare) services — ranging from nursing care to shelter to food to job training and job placement — for Irish female emigrants overseas and other local Catholic populations. Such was the demand for the services offered that the nuns regularly returned to Ireland to recruit others to staff the further expansion of their emigrant services. These care services were significant conduits for the travel of Irish Catholic social teaching worldwide, but they also enabled contact to be

maintained between emigrants and their families in Ireland (orders of nuns were involved in letter writing and delivery which ensured, amongst other things, that remittances actually reached families; see Fitzgerald, 2006) (Yeates, 2009a; forthcoming 2011).

Sodalities (communities of lay and professional female religious) played a critical role in the formation of these care networks. They prepared girls and women for emigration, provided continued spiritual and pastoral support for them after emigration, and were a principal means by which they maintained regular contact with Ireland. Sodalities constituted a circuit by which emigrants kept in contact not only with nuns 'back home' but also with their families (Magray, 1998). Sodalities also played a significant role in the formation of transnational networks of care professionals. For example, the formation of a sodality of Catholic nursing labour force (the Irish Guild of Catholic Nurses (IGCN)) was pivotal in articulating and promoting Catholic nursing ethics and practices to Irish (and non-Irish) Catholic nursing diasporas. The IGCN was a major actor in the formation of a transnational care network of Catholic nurses through which nursing goods, values and ideas were circulated. Its professional nursing journal spread Catholic ideas and ideals of nursing and organized the financing and sending of care goods in the form of supplies of medicinal, surgical and general hospital equipment to missionaries (Yeates, 2009b; forthcoming 2011).

Alongside the effects of distance on the nature of care provision, the remaking of social inequality and exploitation on a global scale has been a particular focus of attention. Care migration entails the extraction of resources from poorer countries and their transfer to richer ones. Deprived of human care labour these extractive processes export to poorer countries social problems created by rich countries' under-investment in public care services. Sustained and intensive migration processes distort and erode social solidarities and the 'emotional commons' that female emigrants would have otherwise sustained in their home countries (Isaksen et al., 2008), while the overseas recruitment strategies of rich countries exacerbate shortages of nursing and medical staff that compromise local populations' access to healthcare services in poorer sending countries. The resultant increase in rates of death, disability and morbidity contribute to a widening population health gap, reduced productivity, and loss of public investment (Awases et al., 2004; Khaliq et al., 2009; OECD/WHO, 2010). It is possible to appreciate how these processes of care labour extraction and redistribution link the deteriorating health status of those in source countries with the improving status of those in destination countries (Yeates, 2011a).

Social relations of exploitation take on a personal dimension as many emphasize how care transnationalization involves not just service provision, but servitude itself. The rise in demand for domestic care labour is embroiled with that of 'post-industrial household structure[s] with pre-industrial values' (Parreñas, 2001), where relations between migrant domestic workers and their employers more closely resemble a state of subjection

(and often in ways that approximate slavery) than one of exchange, freedom and reciprocity (Anderson, 1997; Chin, 1998; Ong, 2006). Indeed, the working conditions of migrant care workers have emerged as a major concern for agencies combating transnational crime in recent years. In many cases women are recruited with promises of legitimate jobs with good pay and conditions; when they arrive in the host country, the promises are revealed to be false (Redfoot and Houser, 2005). An ILO-sponsored study concluded from its review of international evidence that it is in the private sector where unionization rates are low that some of the worst abuses of migrant healthcare workers occur (Bach, 2003: 19), while in some cases the position of nurses closely resembles that of bonded labour more commonly associated with domestic or sex workers (Browne, 2001; Jha, 2007).

The operation of work permit systems in destination countries is a major factor in this exploitation where the employer rather than the migrant owns the permit; but even where this is not the case there is a reluctance to report employer abuse for fear of work permits being withdrawn. A further problem is that migrants overseas can be pressurized into signing a supplemental contract that requires the payment of additional fees. When such problems occur abroad, they are outside the jurisdiction of the source country government (Martin, 2005). This effectively leaves migrant nurses who have legitimate grievances about the terms and conditions of their work in a difficult situation, since their only option is to pursue their complaints with the recruitment agency based in the country of origin. The disparity between the territorial reach of the state, recruitment agencies and labour evident in processes of transnationalization compromises the quality of labour protection (Yeates, 2011b).

Transnational advocacy and policy campaigns have emerged to protect against such abuses, promote migrants' rights and influence policy discourse and formation. Through these organizations, migrant workers, who are often constituted as second-class citizens in the 'host' country, are asserting their rights to be treated as first-class citizens, and constitute themselves as such, through their claims, demands and practices. Amongst the key demands they are placing on reform agendas are labour and residency rights, including rights of family reunification. Supported by labour and social movement organizations within and across countries, such advocacy campaigns are directed at spheres of national governance where discriminatory policy and law are opposed and the practices of recruitment agencies and employers (through individual lawsuits and class action) are contested. This national focus of campaign is in part a function of present institutional arrangements whereby the receiving state, being the body that has ratified international conventions, is the only actor that can take action against the offending party (e.g. employer or recruitment agency).

These campaigns have been instrumental in policy formation processes. The Global Campaign for the Ratification of the UN Migrant Workers

Convention was developed in global spheres of governance, but its implementation was directed at national spheres of governance (to increasing ratifications of the Convention). In 2003 the Philippines successfully led a coalition of six countries (also including Indonesia, Thailand, Vietnam, Myanmar and Sri Lanka) to pressure Hong Kong to withdraw its wage cuts for foreign workers (Oishi, 2005) and transnational advocacy networks filed a complaint to the ILO (Piper, 2007b). Other examples of campaigns initiated by transnational advocacy networks include placing issues of the trafficking of women and children on the global policy agenda, the development of new multilateral rights instruments (ILO Convention on domestic workers 2011, and the WHO 2010 code of practice on international recruitment of health personnel), and defence campaigns for domestic workers accused of crimes in countries such as Singapore and the Gulf states.

These 'bottom up' transnational practices demonstrate that transnational rights campaigns are not always or entirely directed at global institutions and agencies. Indeed, they may harness ideational, discursive and legal tools in support of coalition building and activism involving partnerships of states, NGOs and social movements and directed at spheres of national governance as well as at spheres of global governance. Care values and discourses circulate through these networks. Contemporarily this is evidenced through transnational advocacy networks centred on the defence and promotion of migrant workers' human rights in specific country contexts in ways that echo flows of socio-religious ideas and ideologies of care through border-spanning religious networks (Yeates, 2009b).

Although ideational transnationalization takes place outside the bureaux and boardrooms of elite global organizations, cross-border spheres of governance are a major arena through which such processes are manifested and struggles over ideas and ideologies played out. Of note here is research literature focusing on IGOs' policy discourses and prescriptions regarding childcare policy (Mahon, 2005), healthcare policy (Koivusalo and Mackintosh, 2005; Koivusalo and Ollila, 1997), and gender equality in care giving (Bedford, 2010). While these institutions may not have the necessary political, financial or legal leverage over sovereign governments to effect their direct and immediate implementation, they are nonetheless instrumental in framing normative ideals and ideas about care provision that are translated into 'national' policy debates, options and courses of action. Research has not yet traced the impacts of global care discourse and policy on policy implementation within and/or across country settings, but evidence from other policy areas (Deacon, 2007; Orenstein, 2008; Yeates, 2008) has demonstrated the extent to which global agencies have been involved in the co-construction of 'national' policy and the formation of 'national' regimes in both contemporary and historical contexts.

Overall, this literature effectively highlights the multitude of ways in which social relations, orientations and practices of care are routinely

'stretched' across political (state) borders. This has brought a clear understanding of the regularity of such interactions and the enduring nature of such relations. With this has come an appreciation of the textured and differentiated nature of transnationalization processes and their impacts. Despite the largely 'presentist' focus of much of the care migration literature, neither care labour migration nor the social formations to which it gives rise are historically unprecedented. Contemporary transnational families and transnationalizing (child) care practices have strong historical continuities in practices of children being raised by paid and unpaid care givers across a range of slave, colonial and settler societies (Hondagneu-Sotelo and Avila, 1997; Plaza, 2000; Vuorela, 2003). Indeed, such social formations are best understood as current expressions of an age-old means of fulfilling care responsibilities for a variety of family members — from small children to the ailing aged — when for a range of reasons and circumstances parents (or children) were not able to be physically proximate. Similar precedents to the systemic linkages and relations between recruiting and sending countries' care services can be found in histories of welfare colonialism highlighting how Western ideologies and practices of education, medicine and nursing were spread through migration from colonizing countries to colonized ones. The work of Rafferty (2005) and Yeates (2009a) on the influence of the UK's CAN/ONA on the development of nursing in UK colonies, and the work of Choy (2003) and Brush (1997) on the enduring influence of US intervention on nursing in the Philippines all show how earlier processes of transnationalization laid the foundations for mass recruitment from developing to developed countries that is a feature of contemporary care economies.

Contemporarily, just as in the past, transnationalization processes are neither homogenizing nor homogenized. There are marked differences in their pace, scale and significance within different countries and between different branches of the care sector. For example, there are major differences in the extent to which different recruiting countries are reliant on migrant health workers to staff their workforces and the countries from which they recruit in ways that bear on the expression of transnationalization processes in healthcare policy and provision (Yeates, 2011b). There are also marked differences between migration to provide for the survival of the immediate or extended family in a context where relatives depend on remittances for their economic survival and where state social provision is minimal, and emigration from a country where family members are not dependent on remittances for survival and where state provision is, in global terms, extensive and generous (Yeates, 2009a). Such differences emanate from historical and contemporary global political economies of development including the varied effects of differential health, welfare, trade, aid, development, and immigration regimes governing the scale and pace of transmigration. Place and locality continue to mediate social divisions of gender, class, age/generation, 'race' and ethnicity (Maher, 2003; Manalansan, 2004; Walton-Roberts, forthcoming 2012;

Yeates, 2009a; forthcoming 2012) and these, in turn, shape processes, practices and experiences of transnationalism and the distribution of risks and costs, benefits.

DEVELOPING RESEARCH AGENDAS

This article has reviewed key contours of care transnationalization as a field of research enquiry and as an ongoing social process. It has argued that care is a major transnational social field through which individuals, families, communities, socio-institutional formations, economies and policy actors are routinely connected and positioned across more than one country. Characterized by its attention to transactions among and relations between defined actors operating within contexts of global power relations, care transnationalization research has substantially engaged with and contributed to major policy debates and substantially contributed to broader intellectual endeavours challenging the relevance and coherence of 'container state' notions of social formations (past and present) and welfare systems.

Much of the literature on care transnationalization has been directed at the intersection of producer-based care migration and care restructuring, through which diverse transnationalizing social formations, relations and practices have been documented. This literature has expanded from an initial focus on familial contexts (household-based social care) to more public, institutionalized contexts of health and social care. With this has developed a rich analytical terrain cognizant of the border-spanning, multi-stranded webs of socio-economic relationships and the diverse ways in which they materially and synchronously affect individual and collective welfare at home and abroad. This includes attention to multi-stranded social relations and formations revolving around care provision and consumption, and the significance of care networks as conduits through which economic resources, ideas and practices are circulated. Far from offering banal accounts of uninterrupted flows, seamless circuits, and undifferentiated impacts, due emphasis is given to the incomplete and contested nature of transnationalizing processes and to the contexts in which border-spanning orientations, ideas and practices arise, take shape and 'touch down', including the ways in which the unravelling of care transnationalization is mediated by social divisions of gender, 'race'/ethnicity, class, age, religion and locality.

This literature is not without its omissions and biases. Most of the research has attended to producer-based forms of transmigration of care workers while giving far less consideration to other expressions of care transnationalization. Foremost among these are consumption-based dynamics as a mode of care transnationalization and their implications for social development. One example is the extent to which corporate healthcare markets in medical travel contribute to the care drain through the intermeshing of internal and international healthcare migration and their consequences for access to

healthcare. A second example concerns the extent to which the costs of social and health care are being borne by developing countries in their quest to attract consumer capital through retirement (and medical) migration and what this means for local populations' access to quality services. Research into these forms of care transnationalization would provide useful further insights into the territorial and social distribution of risks, benefits and costs of care transnationalization. Just as too little is known about how these processes are impacting upon the development prospects of poorer countries, so too little is known about ideational forms of care transnationalization. Literatures on care worker migration have tended to neglect how transnational networks act as conduits through which orientations, ideas and ideologies of care are circulated and mediated within and across 'national' terrains. Some work has begun on ideational forms of care transnationalization in relation to IGOs and global agencies, but it is comparatively recent in origin and has not yet concretely attended to how global care policy is translated across different historical, regional, country and policy contexts. There is also a dearth of enquiry as to how ideas about care provision are constructed and flow through transnational networks not involving IGOs, how transnational ideas about care are variously taken up across different country, sectoral and historical contexts, and how ideas about care — wherever they are manifested — are themselves transnational constructs.

None of this negates the need to further examine care worker migration as a mode of care transnationalization. The literature has been biased towards the recruiting experiences of rich Anglophone zones such as North America, Western Europe and Australia, while middle- and low-income countries tend to be constructed as source countries. This overlooks 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, 2011a), especially among non-Anglophone countries. Incorporating the experiences of a wider range of countries, branches of the care economy and occupations would generate a better understanding of different textures of care migration and responses to it in both national and cross-border spheres of governance. At the same time, there is much more scope for research into the ways that producer-based care transmigration (and indeed, other forms of transmigration and transnationalization) is mediated by and played out in and through different socio-institutional formations. Here, the tools of comparative policy analysis need to be deployed to a far greater extent than they have been to date.

This latter signals an essential basis for a continuing and productive dialogue between methodologically transnationalist approaches, which bring a focus on the diverse ways in which transnationalizing phenomena and processes are embedded in social organization, identities, practices and relations of care, and methodologically nationalist approaches, with their attention to socio-institutional expressions of care provision in

a wide array of country contexts. While not underestimating the challenges of such collaboration between two such notably divergent methodological and theoretical approaches, this dialogue must be a key priority for ongoing research into the development impacts of care restructuring worldwide.

REFERENCES

Anderson, B. (1997) 'Servants and Slaves: Europe's Domestic Workers', *Race & Class* 39(1): 37–49.

Asis, M.M.B., S. Huang and B. Yeoh (2004) 'When the Light of the Home is Abroad: Unskilled Female Migration and the Filipino Family', *Singapore Journal of Tropical Geography* 25(2): 198–215.

Awases, M., A. Gbary, J. Nyoni and R. Chatora (2004) *Migration of Health Professionals in Six Countries: A Synthesis Report*. Brazzaville: World Health Organization, Regional Office for Africa. Available at: http://www.afro.who.int/dsd/migration6countriesfinal.pdf (accessed 19 November 2006).

Bach, S. (2003) 'International Migration of Health Workers: Labour and Social Issues'. Sectoral Activities Programme Working Paper No. 209. Geneva: ILO.

Bakewell, O. (2009) 'South–South Migration and Human Development: Reflections on African Experiences'. Human Development Research Paper 2009/07. New York: UNDP.

Baldock, C.V. (2000) 'Migrants and their Parents: Caregiving from a Distance', *Journal of Family Issues* 21(2): 205–24.

Basch, L.N., G. Schiller and C.S. Blanc (1994) *Nations Unbound: Transnational Projects, Postcolonial Predicaments and Deterritorialized Nation-States*. Langhorne: Gordon & Breach.

Bedford, K. (2010) 'Harmonizing Global Care Policy? Care and the Commission on the Status of Women'. Gender and Development Programme Paper No. 7. Geneva: UNRISD.

Bettio, F., A. Simonazi and P. Villa (2006) 'Change in Care Regimes and Female Migration: The "Care Drain" in the Mediterranean', *Journal of European Social Policy* 16(3): 271–85.

Browne, A. (2001) 'Abused, Threatened and Trapped — Britain's Foreign "Slave Nurses"'. *The Guardian* 29 May. http://society.guardian.co.uk/NHSstaff/story/0,7991,497983,00.html (accessed 14 November 2005).

Brush, B.L. (1997) 'The Rockefeller Agenda for American/Philippines Nursing Relations', in A.M. Rafferty, J. Robinson and R. Elkan (eds) *Nursing History and the Politics of Welfare*, pp. 45–63. London: Routledge.

Chin, C.B.N. (1998) *In Service and Servitude: Foreign Female Domestic Workers and the Malaysian 'Modernity' Project*. New York: Columbia University Press.

Choy, C.C. (2003) *Empire of Care: Nursing and Migration in Filipino American History*. Durham, NC: Duke University Press.

Daly, M. (2002a) 'Care as a Good for Social Policy', *Journal of Social Policy* 31(2): 251–70.

Daly, M. (ed.) (2002b) *Care Work: The Quest for Security*. Geneva: International Labour Office.

Deacon, B. (2008) *Global Social Governance and Policy*. London: Sage.

Dicken, P., P.F. Kelly, K. Olds and H. Wai-chung Yeung (2001) 'Chains and Networks, Territories and Scales: Towards a Relational Framework for Analyzing the Global Economy', *Global Networks* 1(2): 89–112.

Escrivá, A. (2004) 'Securing Care and Welfare of Dependants Transnationally: Peruvians and Spaniards in Spain'. Working Paper No. 404. Oxford: Oxford Institute of Ageing.

Fitzgerald, M. (2006) *Habits of Compassion: Irish Catholic Nuns and the Origins of New York's Welfare System, 1830–1920*. Urbana, IL: University of Illinois Press.

Folbre, N. (2002) 'Accounting for Care in the United States', in Mary Daly (ed.) *Care Work: The Quest for Security*, pp. 175–91. Geneva: International Labour Office.

Gustafson, P. (2001) 'Retirement Migration and Transnational Lifestyles', *Ageing and Society* 21: 371–94.

Hochschild, A.R. (2000) 'Global Care Chains and Emotional Surplus Value', in W. Hutton and A. Giddens (eds) *On The Edge: Living with Global Capitalism*, pp. 130–46. London: Jonathan Cape.

Holton, R.J. (2008) *Global Networks*. London: Palgrave.

Hondagneu-Sotelo, P. and E. Avila (1997) 'I'm Here, but I'm There: The Meanings of Latin Transnational Motherhood', *Gender and Society* 11(5): 548–70.

Hooyman, N. and J. Gonyea (1995) *Feminist Perspectives on Family Care: Policies for Gender Justice*. Thousand Oaks, CA: Sage.

Isaksen, L., U. Devi and A. Hochschild (2008) 'Global Care Crisis: A Problem of Capital, Care Chain, or Commons?', *American Behavioural Scientist* 52(3): 405–25.

Jha, N.B. (2007) 'Indian Nurses Forced to Continue Working in Saudi', *Times of India* 17 January. http://timesofindia.indiatimes.com/articleshow/msid-1256307,prtpage-1.cms (accessed 17 July 2007).

Khagram, S. and P. Levitt (2004) 'Towards a Field of Transnational Studies and a Sociological Transnationalism Research Program'. Working Paper No. 24. Cambridge, MA: Hauser Center for Non-Profit Organizations at Harvard University. http://ssrn.com/abstract=556993 (accessed 12 January 2008).

Khaliq, A.A., R.W. Broyles and A.K. Mwachofi (2009) 'Global Nurse Migration: Its Impact on Developing Countries and Prospects for the Future', *World Heath & Population* 10(3): 5–23.

King, R., A.M. Warnes and A.M. Williams (1998) 'International Retirement Migration in Europe', *International Journal of Population Geography* 4: 91–111.

Koivusalo, M. and M. Mackintosh (eds) (2005) *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*. Basingstoke: Macmillan.

Koivusalo, M. and E. Ollila (1997) *Making a Healthy World: Agencies, Actors and Policies in International Health*. London: Zed Books.

Leng, C.H. and A. Whittaker (eds) (2010) 'Medical Travel', Special Issue of *Global Social Policy* 10(3): 287–415.

Lynch, K. and E. McLaughlin (1995) 'Caring Labour and Love Labour', in P. Clancy, S. Drudy, K. Lynch and L. O'Dowd (eds) *Irish Society: Sociological Perspectives*, pp. 250–92. Dublin: Institute of Public Administration.

Magray, M. (1998) *The Transforming Power of the Nuns: Women, Religious and Cultural Change in Ireland 1730–1900*. Oxford: Oxford University Press.

Maher, K. (2003) 'Identity Projects at Home and Labour from Abroad: The Market for Foreign Domestic Workers in Southern California and Santiago, Chile'. Working Paper No. 75. San Diego, CA: Center for Comparative Immigration Studies, University of California-San Diego.

Mahon, R. (2005) 'The OECD and the Reconciliation Agenda: Competing Blueprints'. Ottawa: Institute of Political Economy, Carleton University.

Management Sciences for Health (MSH) (2010) 'Evaluation of Malawi's Emergency Human Resources Programme'. EHRP Final Report, July. London: Department for International Development.

Manalansan, M.F. (2004) 'Queer Intersections: Sexuality and Gender in Migration Studies', *International Migration Review* 40(1): 224–49.

Martin, P. (2005) 'Merchants of Labour: Agents of the Evolving Migration Infrastructure'. Discussion Paper DP/158/2005. Geneva: International Institute for Labour Studies.

Migration Policy Institute (MPI) (2006) 'America's Emigrants. US Retirement Migration to Mexico and Panama'. Washington, DC: Migration Policy Institute. www.migrationpolicy.org/pubs/americas_emigrants.pdf (accessed 8 June 2011).

Morales, O.L. (2010) 'US Citizens Retirement Migration to Los Cabos, Mexico. Profile and Social Effects', *Recreation and Society in Africa, Asia and Latin America* 1(1): 75–92. http://www.spreadcorp.org/rasaala/1VOL1/Morale_75–92.pdf

Muula, A.S. (2006) 'Nationality and Country of Training of Medical Doctors in Malawi', *African Health Sciences* 6: 118–19.

OECD (2006) 'How are Services being Internationalised?'. 7th OECD International Trade Statistics Expert Meeting ITS and OECD-Eurostat meeting of experts in trade-in-services-statistics (TIS), STD/NAES/TASS/SERV(2006)14. Paris: OECD.

OECD and WHO (2010) 'International Migration of Health Workers: Improving International Co-operation to Address the Global Health Workforce Crisis'. Policy Brief, February. Paris: OECD.

Oishi, N. (2005) *Women in Motion: Globalization, State Policies and Labor Migration in Asia*. Stanford, CA: Stanford University Press.

Ong, A. (2006) *Neoliberalism as Exception: Mutations in Citizenship and Sovereignty*. Durham, NC: Duke University Press.

Orenstein, M. (2008) *Privatizing Pensions: The Transnational Campaign for Social Security Reform*. Princeton, NJ: Princeton University Press.

Parreñas, R. (2001) *Servants of Globalization*. Stanford, CA: Stanford University Press.

Parreñas, R. (2005) *Children of Global Migration: Transnational Families and Gendered Woes*. Stanford, CA: Stanford University Press.

Pascall, G. (1997) *Social Policy: A New Feminist Analysis*. London: Routledge.

Piper, N. (ed.) (2007a) *New Perspectives on Gender and Migration: Rights, Entitlements and Livelihoods*. London: Routledge.

Piper, N. (2007b) 'Governance of Migration and Transnationalisation of Migrants' Rights — An Organisational Perspective'. COMCAD Working Paper 22. Bielefeld: Center on Migration, Citizenship and Development, Bielefeld University.

Piper, N. and M. Roces (2003) *Wife or Worker? Asian Women and Migration*. Lanham, MD: Rowman and Littlefield.

Plaza, D. (2000) 'Transnational Grannies: The Changing Family Responsibilities of Elderly African Caribbean-born Women Resident in Britain', *Social Indicators Research* 51: 75–105.

Rafferty, A.M. (2005) 'The Seductions of History and the Nursing Diaspora', *Health and History* 7(2): 2–16. www.historycooperative.org/journals/hah/7.2/refferty.html (accessed 17 July 2007).

Redfoot, D.L. and A.N. Houser (2005) '"We Shall Travel On": Quality of Care, Economic Development, and the International Migration of Long-Term Care Workers'. Washington, DC: AARP. www.mecf.org/articles/AARP_immigrant.pdf (accessed 9 November 2005).

Shimizu, H. (2009) 'Paradise in Dream or in Reality? Japanese Retirees Long-Stay in the Philippines'. Paper delivered at conference Transnational Mobilities for Care: State, Market, and Family Dynamics in Asia, Asia Research Institute, National University of Singapore (10–11 September).

UNESCAP (2008) 'Medical Travel in Asia and the Pacific: Challenges and Opportunities'. Bangkok: UNESCAP.

Ungerson, C. (2002) 'Commodified Care Work in European Labour Markets', *European Societies* 5(4): 377–96.

Vertovec, S. (1999) 'Conceiving and Researching Transnationalism', Ethnic and Racial Studies 22(2): 447–62.

Vuorela, U. (2003) 'Transnational Families: Imagined and Real Communities', in D. Bryceson and U. Vuorela (eds) *The Transnational Family: New European Frontiers and Global Network*, pp. 63–82. Oxford: Berg.

Walton-Roberts, M. (forthcoming 2012) 'Contextualizing the Global Nurse Care Chain: International Migration and the Status of Nursing in South India', *Global Networks*.

Whittaker, A. (2009) 'Medical Travel: Challenges to Equity, Access and Ethics in Asian Health Systems'. Paper delivered at conference Transnational Mobilities for Care: State, Market and Family Dynamics in Asia, Asia Research Institute, National University of Singapore (10–11 September).

Wibulpolprasert, S., C. Pachanee, S. Pitayarangsarit and P. Hempisut (2004) 'International Service Trade and its Implications for Human Resources for Health: A Case Study of Thailand', *Human Resources for Health* 2(10). http://www.human-resources-health.com/content/2/1/10

Williams, A.M., R. King and T. Warnes (1997) 'A Place in the Sun: International Retirement Migration from Northern to Southern Europe', *European Urban and Regional Studies* 4: 115–34.

Williams, F. (2010) 'Migration and Care: Themes, Concepts and Challenges', *Social Policy and Society* 9(3): 385–96.

World Bank (2011) *Migration and Remittances Fact Book 2011* (2nd edn). Washington, DC: World Bank.

World Health Organization (2010) 'International Recruitment of Health Personnel: Draft Global Code of Practice'. A63/8, 15 April. Geneva: WHO.

Yamanaka, K. and N. Piper (2005) 'Feminized Migration in East and Southeast Asia: Policies, Actions and Empowerment'. Geneva: United Nations Research Institute for Social Development.

Yeates, N. (2004) 'Global Care Chains: Critical Reflections and Lines of Enquiry', *International Feminist Journal of Politics* 6(3): 369–91.

Yeates, N. (ed.) (2008) *Understanding Global Social Policy*. Bristol: The Policy Press.

Yeates, N. (2009a) *Globalising Care Economies and Migrant Workers: Explorations in Global Care Chains*. Basingstoke: Palgrave.

Yeates, N. (2009b) 'Migration and Nursing in Ireland', *Translocations: Migration and Social Change* 5(1): 1–20. http://www.imrstr.dcu.ie/volume_5_issue_1/Vol_5_Issue_1_d.pdf

Yeates, N. (2011a) 'The Globalisation of Paid Care Labour migration: Policy Issues and Responses', *International Labour Review* 149(4): 423–40.

Yeates, N. (2011b) 'Ireland's Contributions to the Global Nursing Crisis', in R. Munck and B. Fanning (eds) *Immigration and the Irish Experience of European and Global Transformation*, pp. 35–50. Farnham: Ashgate.

Yeates, N. (forthcoming 2011) 'The Irish Catholic Female Religious in the Transnationalisation of Care: An Historical Perspective', *Irish Journal of Sociology*.

Yeates, N. (forthcoming 2012) 'Global Care Chains (GCCs): A State-of-the-Art Review and Future Directions in Care Transnationalisation Research', *Global Networks*.

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