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Occupational (im)mobility in the global care economy: the case of foreign-trained nurses in Canadian context

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Abstract:

The Twenty-first century has witnessed a number of significant demographic and political shifts that have resulted in a care crisis. Addressing the deficit of care provision has led many nations to actively recruit migrant care labour, often under temporary forms of migration. The emergence of this phenomenon has resulted in a rich field of analysis using the lens of care, including the idea of the Global Care Chain. Revisions to this conceptualization have pushed for its extension beyond domestic workers in the home to include skilled workers in other institutional settings, particularly nurses in hospital and long term care settings. Reviewing relevant literature on migrant nurses, this article explores the labour market experiences of internationally educated nurses in Canada. The article reviews research on the barriers facing migrant nurses as they transfer their credentials to the Canadian context. Analysis of this literature suggests that internationally trained nurses' experience a form of occupational (im)mobility, a paradoxical, ambiguous and contingent processes that exploits global mobility, but results in the stratified incorporation of skilled migrant women into healthcare workplaces.

Keywords: Global Care chains; Nursing; Gender; Professional Occupation, Credentials.

Introduction: Skilled care migration and occupational (im)mobility

Over the last decade feminist analysis of the global political-economy and social policy change under neoliberal transformation has produced important research on the global circulation of care workers and caring. Empirically, the idea of care has been used to conceptualize the incorporation of migrant women (typically from the Global South) into the provision of personal and health services for populations in relatively wealthier nations. One of the most well-known of such conceptualizations is the idea of the Global Care Chain (GCC), which draws upon commodity chain analysis to critically reflect upon the transfer of care up the global economic hierarchy. Criticisms of this approach have suggested the need to expand its application beyond its initial focus on domestic workers in private homes in order to capture variations in skill level and migrant workplaces (Yeates 2004). This article engages with these calls, and examines the labour market experiences of 'skilled' migrants with nursing qualifications in Canada, focusing on the experiences of nurses from the Philippines and India. These two countries are among the top sources for care workers and nurses employed in OECD nations such as the USA (Squires et al 2016), Canada (Walton-Roberts et al 2017), and the UK (Baker 2018). While having skills suggests these nurse migrants may fare better than the majority of less skilled domestic workers, more detailed examination suggests migrant nurses paradoxically experience occupational (im)mobility. This issue is examined through a review of literature that reveals two processes that have been relatively underexplored in the GCC literature; occupational regulation and governance, and occupational interlocking or professional boundary work. These processes are dynamic, and their socio-economic consequences, from the individual migrant to the sending nation, comprise an important area of investigation for global (feminist) political-economy researchers. The final section of the article highlights the increasing embeddedness of care migration in the global political economy, and therefore its ongoing importance as a key social policy and justice issue that is deserving of more critical analysis.

As we move into the twenty-first century several significant and interlinked demographic and political shifts are occurring, including unprecedented population aging, working age population decline in core economies (Eberstadt, 2010), and the increasing role of women in the paid labour force (UNFPA, 2000). Add to these demographic processes the ongoing political restructuring of social welfare toward market based supply side welfare policies (cf. Jessop 1993), and we have the context for what scholars have interpreted as a 'care crisis', particularly in child, elder and other forms of long term care (Mandell, 2013; Williams, 2014). One way states have addressed this is through the use of migration policies to attract mostly female migrant care workers (Le Goff, 2016). For example, in 2010/11, 28.5% of home based caregivers in the OECD were immigrants, about 780,000 people, and foreign nurses represented 14.5% of the combined OECD nursing workforce, equal to a total of 1.2 million nurses (International Migration Outlook, 2015).

These empirical realities highlight why the notion of care has become such an important lens through which feminist theorists examine the global political economy and social policy. As Raghuram (2016) argues, care has empirical and theoretical importance: the provision of care is

a challenge linked to demographic change; care has globalized through spatial strategies adopted by migrants to find work and by hospital administrators to fill vacancies; care is also a political project in terms of how we think about society's reproduction of itself and the valuation of care work. Care demands in high and middle income nations have increasingly been addressed by incorporating migrant women from less developed economies (Hondagneu-Sotelo 1992). These changes have been interpreted as representing the international division of reproductive labour (Parreñas 2000), or the globalization of social reproduction (Misra et al 2006). Such systems of labour transfer have also been successfully termed 'global care chains' (GCC) (Hochschild, 2001), in order to conceptualize the spatially variable inter-regional linkages that exist between those engaged in providing paid or unpaid care work and those benefitting from it. Scholars employing these concepts all concur that the benefits accruing from GCCs tends to collect at the top of the socio-spatial hierarchy, and the whole process is fuelled by and reproduces uneven development (Miraftab, 2011). Ehrenreich and Hochschild (2002, 27) call this a 'care drain', and argue that it presents a modern day version of imperialism based on the extraction of emotional resources. The process has also been conceptualized as the Global North's extraction of care labour leading to the erosion of the global commons (family structures) in the Global South (Isaksen et al., 2008).

The GCC concept has certainly found resonance with feminist scholars in part because it overcomes the tendency toward the de-gendering of work in global production and the absence of the household scale in the analysis of value chains (Yeates, 2004; Dunaway 2014). Part of the political benefit of using a GCC framework is that it overcomes what Wilma Dunaway (2014) characterizes as productivist and masculinist bias against the analysis of how productive and reproductive spheres overlap and intersect. Gender hierarchies, divisions of labour and existing patriarchal norms and systems of organization thus provide the opportunity structures by which women's labour can be spliced into global productive systems. Moreover, states and market based actors can exploit these systems under conditions of socio-economic transformation to enhance women's incorporation into the global care economy (Silvey 2004).

Extending the Global Care Chain Concept

This analysis is framed within the literature that builds on the Global Care Chain concept. While a powerful universal framework for examining the intersections of care and migration, GCC research has been weak in intersectional analyses on race and class (Parreñas, 2012). While gender is central, research has demonstrated a lack of attention to how men are embedded in domestic processes that can be considered as part of social reproduction and care (Kilkey, 2010). This results in the GCC reifying the traditional place of women as primary caregivers, and takes for granted the productive capacities of women as care-givers within the global capitalist economy (Raghuram, 2012). The traditional occupational lens of analysis is also limited, in that GCC research has generally only applied to one type of migrant labour – that of the domestic/care workers in private homes, and it has not been commonly extended to understanding the processes imposed on migrant skilled care workers within institutions. In

response to these limitations Yeates (2004, 379), suggests five ways to broaden research on the GCC concept by incorporating migrant groups; a) from different skill levels, b) from different family types, c) employed in institutional as well as private contexts, d) involved in providing different types of care, and e) with some consideration for the longer historical context. Yeates argues that these modifications, together with a revision of global commodity chain analysis, will “contribute to the development of a feminist theory of services globalization” (Yeates, 2004: 370). Yeates (2009) advances this extension of care chain analysis by advocating for a Global Nurse Care Chain approach (GNCC).

Nursing provides a very rich occupation through which to extend care chain analysis, and is a particularly salient angle from which to explore feminist theories of globalization, social reproduction and care. Nurses represent the largest and most internationalized and feminized section of the health professions (Kurtzman et al 2010), and health care systems have long relied on internationally educated nurses to meet structural shortages (Mackintosh et al 2006). This has led to increasingly globalized markets for the training and international deployment of nurses (Kingma 2006, Baumann and Blyth 2008, Connell and Stillwell 2006, Walton-Roberts 2015). Racial, gendered, classed and other diverse intersectional dimensions have intersected in nursing in multiple ways to produce occupational hierarchies and restructuring within the profession (Moyce et al., 2016). While nursing is a feminized profession with a history of subservience to the medical arm of the healthcare profession (Gamarinkow 1978), it is also an occupation where, despite being feminized, masculine advantage is evident, reflecting the resilience of gendered structural disadvantage across labour markets (Cottingham et al., 2015, Walton-Roberts 2019).

At the macro level the migration of nurses is largely shaped by economic hierarchies, as migration routes are typically from less wealthy Asian, African and Small Island states to the Global North (Crush and Pendleton 2011). The global migration of nursing labour has been conceptualized the exploitation and reproduction of uneven development. For example, Valiani (2012) has argued that US health institutions exploit their use of migrant nurses in order to facilitate hospital and labour market restructuring (see also Aitken, 2007). As such, nurses represent an important occupational case that expresses both micro considerations of how the stratification of feminized care workers occurs in the workplace, and a macro level inquiry into the development consequences for nations engaged in the use of nursing as a form of ‘export industry’ (Rodriguez 2010, Walton-Roberts 2015).

Despite the challenges of this occupational migration system, young people in many lower and middle income nations have chosen health careers specifically because of the migration prospects they offer (Connell 2014; Walton-Roberts et al 2017). Their integration into global markets are key sites through which to understand how care labour is spliced into international markets based on systems of professional credential assessment. The process and architecture of skills assessment relevant to this process has been conceptualized as a ‘regime of skill’ where “skill and competency, as relational constructs, join hands with other social relations to produce differences while maintaining the power and practices of the hegemonic West” (Shan and Fejes

2015,227). Nursing is thus a rich profession through which to examine how global inequality shapes global care chains outside of domestic work, and where institutional employment, and thus formal labour market institutions play key roles.

Occupational (im)mobility in Global Nurse Care Chains

Over a million migrant nurses work in the OECD as nurses, and for many their income and career opportunities can reflect a successful process of occupational mobility. However, there are structural and intimate factors at work that can immobilize the progression migrant nurses experience. While the specific policy context of migrant health worker integration into different national labour markets varies (Picot & Sweetman 2011), there is a structural trajectory of convergence with migrant health workers being incorporated into national health systems facing restructured or diminished state spending (Williams 2014, Yeates 2009). At the micro scale of the individual, migrant nurses have reported that their skills are not fully utilized (Bruyneel et al 2013), and they are concentrated in less desirable nursing posts that require greater ‘body work’ (Dyer et al 2008). These two processes of (im)mobility at the structural and micro scale are examined in more detail below.

I: Occupational regulation and governance

Nursing is considered a skilled profession that generally demands applicants possess a recognised four-year baccalaureate education (or equivalent), satisfactory completion of an entry to practice exam leading to professional state licensure, and typically current membership in an appropriate official professional body. The global migration of nurses has resulted in a range of formal actors becoming involved in the interpretation, transmission, recognition and assessment of relevant credentials for internationally educated nurses (IENs) (Kingma 2006). There are regional differences in how nursing competencies are evaluated, but professional immobility for nurses occurs most clearly through the process of credential assessment that is regulated by professional associations. In Canada these professional associations are organized at the provincial level, and in Ontario, the most populous Canadian province, the College of Nurses of Ontario (CNO) is the regulatory body. These bodies provide a standard against which international nursing education can be measured, but assessment metrics are often interpreted as ambiguous, leading to frustration for IENs who are blocked in their occupational goals (Walton-Roberts and Hennebry 2019, Joel et al., 2018). Sweetman et al., (2015) examine the implications of professional regulation for skilled migrants in Canada and Australia, and their findings are echoed in several European cases (see Schuster et al 2013). Occupational regulation stems from historic guilds that emerged when systems of personal trust could no longer protect clients’ transactional interests. Sweetman et al. (2015) note that by the 1980s the expansion of the number of professions and aggregate number of workers included meant professional regulation surpassed unionization as the major labour market institution. The monopoly benefits that accrue

to regulated professions are akin to unionization, and therefore migrant worker access to these groups significantly determines their career mobility and the kind of return they can hope to receive for their pre-migration training. The key process that determines this outcome is credential assessment, which the professional associations normally manage and control.

Typically, migrant nurses must have their foreign credentials assessed (the evaluation of the education and its equivalency to those used in the intended market), this is often cited as one of the most common barriers that significantly delays or prevents migrant nurses from completing their licensure process (Kolawole, 2009, p.185). Typically nursing regulators require candidates to take an entry to practice exam in order to determine if they meet the program equivalency requirements. In 2016 the CNO received a total of 12,054 applications, 8,964 from Canadian applicants and 2,967 from international applicants. In the same year 8,048 Canadian applicants and 1,263 international applicants become fully registered members; this represents 89% and 42% of the potential applicant pool respectively (CNO 2016). The time frame for assessment varies significantly between applicants, and their place of training is often a key determinant of the outcome (personal communication with CNO officials). In Ontario, the Office of the Fairness Commission (OFC) oversees the evaluation process and reports on the level of transparency, objectivity and fairness involved in the credential assessment process. In 2015 the Ontario OFC cited a number of concerns with several processes used by the CNO. This included: costly and time-consuming retraining and bridging programs required of IENs, limited spaces in training programs; lack of justification for some of the exams IENs are subjected to, and a lack of clarity regarding how the results of such tests are evaluated (OFC 2015). As a skilled occupation nursing should be subjected to formal governance mechanisms, but the process of evaluation was seen as exhibiting arbitrary and restrictive approaches not fully explained or justified. The struggle of IENs to complete the steps required by the CNO has recently led to the formation of the Ontario Internationally Educated Nurses Course Consortium (OIENCC), a collection of four public universities working together to provide courses to address competency gaps:

For many years the struggle facing IENs has been strongly felt. Since 2013, the College of Nurses of Ontario (CNO) has been assessing the competencies of IENs who want to practice in Ontario, and advising them that they must undertake recognized baccalaureate-level education in order to address any identified competency gaps. As a consequence, with relatively few university-level spaces currently available for IENs, thousands have been left stranded in their efforts to become RNs in Ontario (Council of Ontario Universities 2017).

A major determinant of the credential assessment process is the location where the original training occurred. It is here that the issue of uneven development and spatial difference plays an important role in how IENs are stratified into the labour market. The Philippines was for some time the leading nurse source market for Ontario, but has recently been surpassed by India. In 2017 the CNO received 1,908 applications from India and 1,441 from the Philippines, the next was Nepal at a distant 54 (CNO 2017). The channels drawing these nurses into the Canadian

system are not random, the Philippines has explicitly oriented the training of their nurses to service international markets (Cabanda 2017).

India has also seen rapid growth of the nursing education sector through significant private sector investment (Walton-Roberts 2015). However, the rush to expand nursing education for overseas markets has been built on a profession that suffers from low status and inadequate state investment. India has been struggling to revise its medical professional regulation systems in light of widespread corruption concerns (Kane and Calnan, 2017). The idea of the GNCC is relevant in understanding this dynamic because India's nursing profession has been subjected to gendered hierarchies, divisions of labour and existing patriarchal norms and systems of organization domestically where nursing is deemed subservient to medicine, and the state has not seriously addressed the negative employment conditions for nurses (Varghese et al 2018). This is exactly the argument Dunaway makes about every economic system reflecting the gendered patriarchal norms of its society (Dunaway 2014, 8). Spatial and institutional differences become fundamental to the stratification of migrant workers into destination markets (Squires 2010). Despite some efforts to improve the status of nursing in India, the lack of serious attention to defining professional standards in extant legislation restricts and increases the barriers to nurses' international mobility (Benton et al 2014). The weak and imprecise governance of the profession in one location means that when nurses enter more strongly regulated systems of occupational oversight such as Canada, individuals have to take on the challenge of making their professional subjectivity fit the new mould. Structural inequalities represent the effective transmission line between systematic gendered subordination in the source and individualized systems of verification in the destination region. Such structures have to be overcome by the migrant, and their success will determine the degree of occupational (im)mobility they experience.

II: Occupational interlocking.

In the case of Indian trained nurses, seemingly deficient regulatory contexts in one system are embodied in feminized migrants, who then have to renegotiate and reterritorialize their own professional status to meet the demands of the destination market. But, beyond this regulatory governance portal, migrant nurses also face multiple forms of labour market stratification beyond the regulatory credential verification process. Understanding this as part of an expanded GCC, or GNCC reveals how spatial interlocking of various occupational chains occurs in institutional as well as domestic settings. Care work in institutional settings entails several interlocking occupations that shape the wider chains of care, this element of analysis is key to expanding the focus Yeates (2009) has encouraged GCC scholars to engage in in order to developed a feminist analysis of global services.

Occupational interlocking begins prior to departure depending on the specific schemes individuals use to move. State and non-state actors organize and manage different channels of labour migration, and in the process specify the occupation and the type of work that will be undertaken. In some cases the skills candidates have previously developed (such as English

language and medical knowledge) are exploited in the recruitment process through insertion into less skilled occupations; “why hire a nanny when you can hire a nurse”— is the mantra recruitment agencies might use to promote their services (Walton-Roberts and Hennebry 2013, Pratt 1997). The long term role of the migration pathway for care migrants can be demonstrated with the now disbanded Canadian Live in care Program (LCP), which until 2014 was a major pathway for many Filipino trained nurses to permanently settle in Canada (Boyd, 2017).

The LCP originated in 1981 to allow Canadian citizens or permanent residents to hire foreign caregivers to provide care on a full-time live-in basis. The program allowed qualified individuals to provide care to children, the elderly, and persons with disabilities in private homes, and to eventually settle permanently in Canada. LCPs were required to complete 24 months of full-time employment within 48 months as caregivers prior to applying for permanent residency (Hodge, 2006). The popularity of this program meant that the deskilling of the migrant was sometimes built into the recruitment process before they even departed home. Individuals with qualifications that exceed those needed for such immigration programs often enrolled because they had no viable employment opportunities at home (Gardiner Barber 2008). Researchers have shown this to be evident for workers who possess various health care qualifications, such as physical therapists and nurses (Nyaga and Torres 2017). While the LCP was a dependable transitional pathway to permanent residence status, nurses who entered Canada through this program faced many challenges to re-entering the profession after they had completed the necessary period of being a live in caregiver. For example, nursing regulatory bodies require evidence of recent safe practice as a nurse within a specified period of time prior to registration (in Ontario this is now within the previous 3 years). But for nurses who enter under the LCP, they had to first complete the mandatory 2 years of work before they were eligible to apply for licensure. At best, this invariably meant that fulfilling other time-sensitive licensure requirements posed an immense challenge (Kolawole, 2009; Salami and Nelson 2014).

In the 1990s and 2000s the employment requirements for permanent status eligibility under the LCP combined with increasingly restrictive nursing credential regulatory changes to result in a generation of LCP migrants who were nurses, but who effectively forfeited their eligibility to ever apply for licensure as such (Walton-Roberts and Hennebry 2013). This is an important example of what scholars have termed boundary institutions; processes or structures that shape how workers are supplied to the labour market and their long term experiences (Peck 2001). Banerjee et al., (2018, 932) have shown how immigration policy, specifically the LCP, operated as a boundary institution for LCP applicants from the Philippines since; “even as the period of settlement lengthens, caregiver immigrants are still working in a narrow and related set of feminized and racialized occupations.” This reality is also supported by Ontario data showing that the foreign born and educated are half as likely to be in the occupation for which they trained as the Canadian born and educated (Augustine 2015). For example, 85% of Canadian born and educated doctors were employed as doctors compared to 36% of the foreign born and educated, for nurses it was 71% and 53%. When the data was further analysed to determine

whether those not in their occupation were actually in a higher skilled occupation, the differences between doctors and nurses was stark. Those immigrants not working in medicine were often in higher skilled research, policy and management positions, but for migrants not in nursing, the top alternative occupations included nursing aides, domestic work, homemakers, practical nursing, baby sitter occupations and cleaners; positions *not* commensurate with their pre-migration training. This occupational interlocking between pre-migration and post migration occupational status reflects a distinct deskilling of mainly immigrant women. This illustrates the importance of understanding how occupational interlocking shapes the GCC in terms of the immigration and occupational pathways migrants are stratified into, and the ongoing negative material outcomes of such processes.

Careful analysis of the interlocking of occupational and migration processes is key to understanding how labour market stratification occurs within care chains, and as Banerjee et al (2018) reveal, immigration policy acts as a boundary institution with long term consequences exacted on care workers. Even though the LCP has been disbanded, the model of conversion from one visa status to another that is emblematic of this system remains active in Canada and central to aspects of the GNCC. Over the past 10 years Canada's immigration system has increasingly moved from a primarily one-step immigration process that provides permanent residence to increasing two-step migration processes using temporary immigration routes. An example of this is Canada's growth in international students; a system that allows international students to apply for post-graduation work permits in order to work legally in Canada following the end of their study. International student visas are increasingly used by trained nurses to enhance their education while simultaneously negotiating the credential and qualification assessment process. Research in Ontario (Williams et al 2015) explored a cohort of international students enrolled in a post-graduate nursing program and indicated that 96% of the students either wanted (43%) or possibly wanted (43%) to remain in Canada. However, postgraduate transition data from the college suggests that only 26% of those students were later working in Canada as registered nurses or registered practical nurses. Interviews with the cohort indicated long wait times to complete the various examinations, confusion on the part of the CNO regarding their eligibility to apply for registration according to the individual's visa status, more restrictive and confusing testing requirements, and demands for enrollment in bridging courses that were heavily oversubscribed. Those who secured recognition had to manage their multiple visa status as well as possess the patience, fortitude and financial capital to progress through the credential and qualification maze (Egenes, 2012).

The nature of nursing work involved various forms of interaction with other care workers, including medical professionals and junior cadres of workers. Such workers include those nurse migrants who have been frustrated by regulatory barriers but who may take up positions with lower status and scope of practice such as Registered Practical Nurse, or personal support workers (Salami et al 2018). The relative success or failure of international versus Canadian trained nurses to pass the regulatory process results in a racial, ethnic and nationally categorized

and stratified workforce. Whether intentional or not, the outcome is a workplace where difference becomes inscribed in the multiple professional statuses represented.

Once in the nursing profession there are still structural barriers to contend with. Key to this process is labour flexibilization (Valiani 2012), the systematic weakening of nurses' unionized strength in favour of employers, driven by a commodified health care system, rising costs, and the drive to lower labour costs. The case of flexibilization indicates how power is differentially distributed through the relative status of medical professional groups, with high status groups naturalizing their position as central to the system in order to protect their members' scope of practice and monopoly power over that of nurses and other healthcare workers (Bucher et al., 2016). This can be seen in the case of doctors resisting the widening scope of practice for nurse practitioners and midwives (Bourgeault 2006). For registered nurses, their middle status position means they have to make a case for their professional standing against senior *and* lower status professions, since they need to denaturalize the power of physicians in order to enhance their own scope of practice, while protecting their own status (Bucher et al 2016). This contributes to reproducing stratified occupational hierarchies and intensifies boundary discourses between nursing groups (cf. Limoges and Jagos 2015), boundaries that are intensified through ethnic, racial and regional differences (McDowell 2015).

Care migration's embeddedness in international /global political economy.

To understand how the migration and labour market stratification of health workers is managed, the 'global care chain' concept needs to be modified in order to overcome its "lack of embeddedness in a critical international political economy perspective" (Yeates, 2004:370). A critical international political economy perspective reveals the interlocking nature of different care chains to understanding the very nature of production within national managed systems, and how workers are positioned within productive systems in destination location, this includes assessment of how immigration policies becomes a key boundary institution at work in the production of deskilled and devalued feminized and racialized care workers (Banerjee et al 2018). The intersection of care chains globally can be understood in light of formal policy frameworks as well as informal networks of recruitment. Care chains can be manifested locally or may be international or inter-regional in scope, for example the migration of health workers is increasingly operating as a form of export industry for both the Philippines and India (Rodriguez, 2010, Walton-Roberts et al 2017). The systematic development of such export policies provided care workers from the Philippines into Canada's LCP program, which is the product of a highly formalized policy process that incorporates sending and receiving policy frameworks (Cabanda 2017).

For Indian nurses using the international student pathway, the care chain is the product of the interaction of increasingly marketized nurse education and training together with existing international migration infrastructure (Walton-Roberts 2015). The global care chain concept provides explanatory framing, but the policy context at both ends of the chain differ and produce great variability in terms of the rights, protections and working experiences of individuals. In the

case of nurses this demands deeper understanding of the educational and health care sectors in specific sending and destination regions and the forces of transformation that are operating upon them (Yeates 2012,). Effective analysis of these social policy spaces (health, education, professional regulation, immigration) tends to relegate the *global* interlocking nature of care chains to a secondary factor, since attention tends to be focused on the specific *national* context as the immediate frame of reference for analysis. A form of methodological nationalism thus tends to attach to research on changing employment conditions, skills training, health, professional regulation and immigration policy. This is short-sighted in many contexts since *international* pressures and expectations are shaping and transforming training and skills agendas in the health sector (Connell 2014, Walton-Roberts 2015).

The transformations in nursing education in two of the biggest source markets (India and the Philippines) is mediated by institutional groups such as recruiters, professional associations, state governments, private educational and medical interests and internationalized health testing and education groups, leading to an increase in private education, and the concomitant increase in tuition fees. For example, 90% of India's nursing educational institutions are in the private sector (FICCI 2016, 23). The globalization of such a vital form of expertise has profound implications for the distribution of this form of care; it also suggests that the system itself is becoming a self-reproducing one where various state and non-state actors are feeding global care circulations in a manner that creates highly contingent and ambiguous outcomes. It suggests that regardless of the difficulty migrants might face in the migration process and the degree of occupational (im)mobility they experience, the system will continue to generate candidates willing to enter it. Researchers need to understand how these tendencies intersect across multiple scales *and* across changing occupational sectors.

Conclusions

This article explored how the Global Care Chains (GCC) lens has become a powerful conceptual approach for understanding the dynamics of contemporary demographic and political change, and the place of feminized and racialized care migration within it. The GCC approach provides an explicit feminist reading of the structural conditions that are creating the context for care labour circulation, how that care labour is devalued through processes of segmentation and regulation, including through immigration and citizenship policy (Banerjee et al 2018; Buckley et al., 2017), and labour market and credential assessment processes (Shan and Fejes 2015). Intellectual engagements with the GCC concept have extended its application to a wider range of occupations and institutional settings, including more highly skilled and regulated professions such as nursing. Nursing is a rich and productive occupation to engage with in order to assess social policy and political-economy transformations. As the largest professional category within health care, nursing is positioned in important ways as a barometer of the changing approaches to delivering health care in an age of globalized, increasingly privatized and marketized health services. Nursing is also a rich occupational lens through which to explore the integration of immigrants into formal regulated occupations managed by professional associations, which are increasingly important

workplace institutions themselves. Regulation of migrant workers occurs most directly and most frustratingly from national professional associations (at home and overseas), who control the credentials and qualification process and who are charged with maintaining the quality and integrity of the system. While public safety is arguably their main concern, the monopoly position and political influence they hold makes regulating the regulators a challenge. This form of labour market institution has come to play an oversized role in the experiences of migrant nurses and is one of the main conduits through which occupational (im)mobility is registered.

The present analysis showed that, at the macro level, nurse migration routes reflect a distinct directionality that highlights less developed to more developed migration (be it south to north or east to west). As such the process is recognized as reproducing (indeed exploiting) uneven development that exists in terms of income, but also in terms of the governance and professional status of occupations. At the micro scale the experiences of migrant nurses as they attempt to navigate the process of having their credentials recognized and transferred to new sites of employment is one full of barriers. Framed as occupational (im)mobility, these multiple processes are detailed to reveal a paradoxical and ambivalent situation where the increased global mobility of trained nurses often results migrant nurses' occupational immobility at the workplace in the destination location, with many nurses being frustrated by their devalued positioning in highly stratified and segmented workplaces.

The article argued that this overarching system of occupational regulation and governance creates the potential for professional (im)mobility for migrant women who once trained as nurses. Occupational mobility can be a positive force for individuals, and is actively promoted through the globalization of health professions. However, such mobility is also deeply ambivalent, since what is promised and what is delivered varies, and the process of relocating labour involves various qualification and credential assessment processes that can block or at least immobilize some forms of occupational progression. Occupational governance and regulation for skilled care professions is one of the sites that must be interrogated when trying to understand the interplay between the source and destination structures of gendered inequality, these play a key role in shaping and differentiating global care chains, this includes how the poor status of nursing in some source regions (Philippines and India) frame the context of credential assessment for IENs in destinations (Canada), and how in managing the complexity of this uneven landscape of professional regulation, systems of credential assessment emerge that can be ambiguous, occasionally unclear and often detrimental to the professional mobility of skilled care workers. Credential assessment and its regulation is one realm where the individual may embody uneven development allowing them to be subjected to the transmission of wider structures of gendered inequality and hierarchy, thus informing how migrant feminized workers are spliced into hierarchal labour markets.

The analysis showed that the integration of migrant care workers also needs to be understood at the level of workplace occupational interlocking. Prior to departure migrants are sometimes constructed to fit state mandated migration policies. Sometimes nurses are deployed as domestic workers, and their deskilled position is thereby formalized before they even leave home.

At the destination there are numerous ways in which labour market positioning and stratification can occur. Again the migration route selected and the visa used will determine the ability of migrants to make it through the processes of accreditation before they can enter practice. If migrant nurses do make it through the regulatory process, their experience in the workplace suggests they feel undervalued and experience less advancement. Evidence from Canada and other OECD nations also reveals the fact that migrant nurses are more likely than Canadian born to not be working in their profession, but more likely to be employed in professions not commensurate with their prior training.

Conceptually, the analysis presented in this article has taken to heart Yeates (2004, 2009) call for care chain analysis to be embedded in international political economy; the article has suggested that the global migration of nurses is generated and maintained by a range of transnationally orientated state and non-state bodies, but is also reflective of broader forms of structural inequality. Increasingly, the very entry into the nursing profession in key source nations is to commit to become locked into international nursing markets. Health institutions are themselves increasingly embedded into global service networks; International training agencies are shaping systems of education and assessment that funnel workers into apex markets such as the USA, UK and other OECD markets. Occupationally specific hierarchies inform how migrant nurses will experience already stratified workplaces, where relations with health professionals at the top, middle and lower ends of the status hierarchy are pre-defined by dominant patterns of professional boundary work, systems of health restructuring that exploit such power imbalances, and the work of immigration policy itself as a boundary institution that assures the long term spatial and occupational (im)mobility of migrant care workers embedded in Global Care Chains.

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